TERMS OF REFERENCE
NATIONAL NATIVE ALCOHOL AND DRUG ABUSE PROGRAM

GENERAL REVIEW

NATIONAL NATIVE ALCOHOL AND DRUG ABUSE PROGRAM

GENERAL REVIEW

1. BACKGROUND:

The National Native Alcohol and Drug Abuse Program (NNADAP) is an example of an MSB program now largely controlled by First Nations communities and organizations. Now in its fifteenth year, the NNADAP program includes a network of 54 treatment centres that represent approximately 700 inpatient treatment beds. As well, there are more than 500 alcohol and other drug abuse community based prevention programs with approximately 650 workers now active in community based prevention activities. 96% of the NNADAP resources are managed directly by First Nations through contribution and/or transfer agreements.

The goal of NNADAP is to support First Nations and Inuit people and their communities in establishing and operating programs aimed at arresting and off-setting high levels of alcohol, drug, and solvent abuse among their target populations living on-reserve. Most of the NNADAP activities are included in the following four areas of emphasis: prevention, treatment, training, research and development.

NNADAP has evolved through many stages, including identification of needs, program development and implementation, program maintenance etc. Alcohol and other drug abuse is a major health issue, and is a symptom of the continuing and complex issues related to the psycho-social health and wellness of First Nation individuals and communities. This is a priority for First Nation and Inuit people.

NNADAP has never been reviewed in its entirety, however, it was evaluated once in 1989. This evaluation included several recommendations aimed at making the program more effective and efficient, and to more closely meet the basic goals and intent of the program.

As MSB moves towards realizing the Branch Vision that "First Nations and Inuit people will have autonomy and control of their health programs and resources within a time frame to be determined in consultation with the First Nations and Inuit", it is now timely to re-examine NNADAP and determine what, if any, modifications should be considered in order to ensure that a viable and appropriate program is in place.

Through an informal process of discussion with a variety of players involved in a wide range of NNADAP activities, including prevention and treatment, a number of priorities were suggested for examination. Some of these issues include funding for NNADAP centres, demonstrated quality assurance of NNADAP services, current NNADAP reporting systems, as well as training and standards for prevention and treatment workers.

These and other issues identified subsequent to the discussion process will be examined in conjunction with the NNADAP Review exercise.

2. PURPOSE OF THE NNADAP REVIEW:

2.1 To determine the overall effectiveness of the National Native Alcohol and Drug Abuse Program;

2.2 To guide the development of strategic recommendations to strengthen First Nations and Inuit programming in relation to alcohol and drug abuse by both MSB and First Nations communities

2.3 The Review is intended to support First Nations, Inuit and Medical Services Branch in their effort to ensure the most effective use of the NNADAP program at the community level.

3. SCOPE:

Review activities will be conducted in the context of the following general questions:

3.1 What was the original intent and contextual environment of NNADAP? What has the program accomplished? Is NNADAP achieving what it was originally established to do?

3.2 Who are the stakeholders and what are their roles and responsibilities in relationship to NNADAP?
What are their perceptions of NNADAP?

3.3 What impact does NNADAP have on First Nations and Inuit people and communities?

3.4 What are the strengths and weaknesses of NNADAP?
What are the opportunities and challenges for NNADAP? How can delivery of

its programs be improved?

3.5 How does NNADAP relate to the provision of other programs at the community level?

The study is to be broken down into the following components:

4. LITERATURE REVIEW:

A comprehensive literature review on substance abuse among First Nations and Inuit people. The literature review should:

4.1 be based on, but not limited to the continuum of care concept, including previous reviews (ie 1989, as well as project based studies), and existing evaluation practices;

4.2 contain some relevant international and non-native comparisons;

4.3 include information from the Treatment Activity Reporting System, also examine Non-Insured Health Benefits data in relation of cost, number and types of treatment referral to NNADAP/Non-NNADAP treatment centres;

4.4 Long Term Evaluation of Transfer-Final Report and MSB documents related to transfer policies;

4.5 Information gathered as part of this exercise should relate to, and be used where pertinent, to support any findings and recommendations developed in conjunction with the analysis of NNADAP programs and services.

5. ANALYSIS OF THE NNADAP PROJECTS AND SERVICES:

Identification, description, analysis of the NNADAP projects and services and recommendations with respect to:

5.1 Program governance;
5.2 Program accountability;
5.3 Roles and responsibilities of stakeholders;
5.4 Availability, adequacy and accessibility of programs and services;
5.5 Need for cross-addiction and multiple addiction substance abuse programs and

services for First Nations and Inuit communities;
5.6 Impact of programs, services and care;
5.7 Stakeholder satisfaction and perception of the NNADAP projects/services;
5.8 Gaps in service delivery in relation to the continuum of care concept;
5.9 Linkage to and impact of provincial programs and other agencies;
5.10 Improvements to enhance overall effectiveness of programs and service delivery;
5.11 Relationship of NNADAP with other community based services;
5.12 Impact of transfer related policies and practices;
5.13 Implications of devolution and transfer of programs and services for First Nations governance;
5.14 Financial and human resources;

6. SPECIFIC REVIEW ITEMS:

The Review will address the following issues specifically, as part of the above mentioned analysis:

6.1 Funding of the NNADAP (Prevention and Treatment)

6.1.1 Past and current funding methods for NNADAP
6.1.2 Strengths/weaknesses of the NNADAP funding formulae
6.1.3 Funding principles
6.1.4 Models of different funding methods or systems
6.1.5 Recommendations on the funding of the NNADAP components
6.1.6 MSB breakdown of program resources
6.1.7 NNADAP financial relationship to other programs (e.g. NIHB)
6.1.8 Community workload increase system (CWIS) funding formula

6.2 Standards and Accreditation process for NNADAP (Prevention and Treatment)

6.2.1 Identification of programs or services that would require standards.
6.2.2 Existing standards for substance abuse programs (national and international)
6.2.3 Possible accreditation models and processes
6.2.4 Recommendations

6.3 Training (Prevention and Treatment)

6.3.1 Review training, accredited or other related standards for the NNADAP workers
6.3.2 Review of training needs of the NNADAP workers

6.3.3 The types and availability of alcohol & other substance abuse training

6.3.4 Review of the training approach for the NNADAP
6.3.5 Recommendations

6.4 NNADAP Data Collection and Reporting Systems (Prevention and Treatment)

6.4.1 Definition and review of the NNADAP information system
6.4.2 Identification of the potential users of the NNADAP information system
6.4.3 How is the existing system specifically meeting and not meeting the needs?
6.4.4 What are the alternative/solutions to meeting those needs?
6.4.5 Should and can the new system be part of/or be compatible with other national health data collection system (e.g. the health information system).
6.4.6 Recommendations on the type of information needed and systems for the NNADAP projects.
6.4.7 Community workload increase system data collection methodology.

6.5 Transfer Policies and Practices (Prevention and Treatment)

6.5.1 Current approaches being taken in the Regions with respect to NNADAP transfers
6.5.2 Impact of current transfer policies on NNADAP
6.5.3 Recommendations

6.6 Relationship of NNADAP Projects/Services with other Community Based Services

6.6.1 To what extent is NNADAP currently involved with other programs

and services at the community level
6.6.2 Identification of advantages and disadvantages to coordinate NNADAP with other community based services
6.6.3 Recommendations

6.7 NNADAP Research and Development

6.7.1 What is and was the nature and extent of community based and national NNADAP research and development activities
6.7.2 How do these activities relate to the delivery of NNADAP programs and services
6.7.3 Can and should research and development activities and outputs be more effectively linked to the delivery of NNADAP programs and services
6.7.4 Are there other viable alternatives to the present approaches being taken with respect to NNADAP research and development

6.8 NNADAP Evaluation Practices and Procedures

6.8.1 What practices are followed at community, regional and national levels
6.8.2 What performance indicators/measurement tools are used
6.8.3 Are current practices adequate - deficiencies
6.8.4 Are there best practices of other community oriented Drug and Alcohol Abuse Treatment/Prevention Programs and other MSB programs that could be adapted to NNADAP
6.8.5 Recommendations

6.9 NNADAP workers scope of duties

6.9.1 What is the scope of practice for NNADAP treatment and prevention workers?
6.9.2 Roles and responsibilities of NNADAP treatment and prevention workers.
6.9.3 What was the original role of the NNADAP treatment and prevention workers?
6.9.4 Has the NNADAP treatment and prevention worker's role changed? (diminished or increased)

6.9.5 Recommendations on the scope of duties for NNADAP and treatment workers.

7. MANAGEMENT STRUCTURE:

A Steering Committee will be established to oversee the NNADAP Review process. Program technical support and coordination to the Steering Committee will be provided by the Health Programs Support Division of FNIHPD.

An outside consulting firm will be hired to carry out the actual review of NNADAP.

8. COMPOSITION AND RESPONSIBILITIES:

The NNADAP Review Steering Committee is based on an equal partnership approach between First Nations and Medical Services Branch. The NNADAP review should be conducted in the spirit of partnership and full transparency of information.

The Steering Committee is co-chaired by the Director General of First Nations and Inuit Health Programs Directorate and a First Nations representative nominated by the Society of Aboriginal Addictions Recovery (SOAAR).

Membership shall include one Medical Services Branch Regional Director, one representative from the Regional NNADAP consultants and two representatives of the Assembly of First Nations.

The Steering Committee will be responsible for:

- development of a Terms of Reference and general milestones for the review process;
- contractor selection;
- monitoring the review process and providing general guidance to the contractor;
- sign-off on review deliverables;
- liaising with Branch senior management in headquarters and the Regions and other key stakeholders concerning review activities;
- presenting the final report to the Branch Executive Committee.

9. MEETINGS AND RESOURCING OF STEERING COMMITTEE ACTIVITIES:

The Steering Committee will meet or teleconference monthly depending on agenda requirements. The quorum for the meetings will be five out of six members.

Travel related costs of the MSB representatives on the Steering Committee will be covered through their respective RCMs. HSPD (FNIHP) will be responsible for travel related costs of non-public servants participating on the Steering Committee.

10. REVIEW METHODOLOGY:

The contractor in consultation with the Steering Committee, will:

10.1 Develop a framework for the conduct of the review, including a detailed workplan;

10.2 Provide written monthly progress reports to the NNADAP Review Steering Committee;

10.3 Use culturally sensitive data and information collection methodologies which also take into consideration and respect confidentiality and privacy requirements. Methodologies will include:

- Determination of data and information collection requirements;
- Identification of collection samples that will cover the major areas of emphasis of the NNADAP and will be representative of all the MSB regions including the Yukon and the NWT. (It should also include the same programs that were surveyed during the 1989 evaluation and transfer communities);
- Determination and development of data collection strategy and related work instruments;

10.4 Present draft and final reports to the NNADAP Review Steering Committee and Branch Executive Committee.

National Native Alcohol and Drug Abuse Program General Review 1998

FINAL REPORT

ACKNOWLEDGMENT

The Review Team would like to acknowledge the hospitality and openness of the First Nations and Inuit people who have contributed to this study. The contributions of Team members of field visits were important and are appreciated. In addition individuals such as Dr. Fred Wien, who contributed their comments and expertise are also valued. The following individuals played various roles in this study:

> Michel Allard, Iris Bear, Judy Blackburn, Daniel Bork, Regina Borneyc, Laurel Lemchuk-Favel, Donnie Garrow, Kathy Jock, Alethea Kewayosh, Hilda King, Louella Lazore, Cindy Lazore, Tina Leblanc, John McCready, Bill Miller, Shaylene Paul, Yvonne Still, Robin Stone, Julie Toulouse, Noella Toulouse, Benoit Tremblay.

The Review Team consisted of Maggie Hodgson, Paul Hanki, John Paul, Virginia Toulouse and Richard Jock.

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National Native Drug and Alcohol Abuse Program (NNADAP)

General Review 1998

1.0 INTRODUCTION

The review of National Native and Alcohol and Drug Abuse (NNADAP) that is presented in the following pages is the result of a considerable chain of developments. The Review was initiated since there had been only a limited review of NNADAP in 1989. It was timely to re-examine the program to determine any modifications that should be considered to ensure that a practical and appropriate program is in place.

The NNADAP review process was guided by the NNADAP Review Steering Committee (NRSC) and was intended to be conducted in the spirit of partnership and full transparency. It was a principle of this Steering Committee that the key elements of a successful review would be in openness, the sharing of information, and input of First Nations and Inuit people towards the review. The Steering Committee was formed based upon a partnership approach between First Nation and Medical Services Branch of Health Canada. The members of the NRSC are:

Deanna Greyeyes, Co-Chair, Society of Aboriginal Addiction Recovery
Paul Glover, Co-Chair, Director General, Medical Services Branch
Chief Lindsay Kaye, Sakimay First Nation
Paul Kyba, Associate Regional Director, Pacific Region
Ronald Linklater, A\NNADAP Consultant, Manitoba Region
Lisa Tabobondung, Assembly of First Nations,
(later replaced by Keith Conn and Elsie Casaway)

A First Nations firm, selected under the set-aside program for Aboriginal Business through a tendering process, conducted the review. It was guided by terms of reference (see annex I) developed by the Steering Committee over a two year period.

The review process was carried out under a multi-phase approach to assure that there is a high level of cross-referencing of findings. The Review process was as follows:

- A Literature Review was conducted on the field of addictions, evaluation methodologies in the field of addictions, and an analysis of relevant research and studies in Aboriginal addictions. The literature review is attached as Annex II.

- Interviews of key informants both within First Nations and within Health Canada were carried out to determine the major issues that were of concern to the key stakeholders.

- Mail out surveys were developed and approved by the NRSC. These surveys were targeted at:

  1. NNADAP workers
  2. First Nations and Inuit leadership
  3. Health workers at the community level
  4. Social services workers at the community level
  5. Senior management of treatment centers

- The return rate for these surveys were as follows:

NNADAP Workers total response	*285 or 48%;*
Leadership total response	*179 or 30%*
Health Services total response	*205 or 35%*
Social Services total response	*191 or 32%*
Total responses	*860 or 37%*

- The surveys were coded and frequency reports were compiled for each group. These reports are attached as Annex IV.

- Field visits were carried out with 37 communities based upon a process of random selection. During site visits the following groups were targeted for interviews: Chief and Council, health workers, social services workers, NNADAP workers, community members focus group, treatment center focus group. Interviews were carried out largely during the months of June, July, and August with some communities finished in the fall of 1997. Site visits were open-ended experiential discussions based upon field visit instruments approved by the Steering Committee. Summaries of these interviews are included as Annex V.

- Following conclusion of the field visits, the review teams met to discuss the main findings of the community based visits. The results from these visits were incorporated into draft findings, which were then presented to the Steering Committee as well as to relevant focus groups as described in the following section.

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* Annex V (Summaries of Interviews) is not included in this Report for the purpose of brevity, but if required can be obtained from: Health Canada, First Nation and Inuit Health Programs Directorate, Jeanne Mance Building, Tunney's Pasture, Ottawa, Ontario, K1A 0L3.

- More detailed studies were carried out on the literature, and on the financial history of NNADAP. These studies are attached as Annexes II and III.
- The study design assured cross-referencing of findings by using various respondents and processes for information gathering. There was a remarkable consistency among respondents.
- Focus group sessions were held in all regions at various stages of the review. The focus groups provided useful feedback to the review team and confirmed the approaches taken for the review. The results of the focus groups are attached as Annex VI. Part of the design of focus groups was to provide preliminary feedback on the outcome of the review.
- General findings, frequency reports from the mail survey, and draft recommendations were presented to the Steering Committee on November 10, 1997. Analysis and synthesis of findings proceeded over December 1997 and January 1998, with report drafting taking place over the months of February and March 1998.

2.0 BACKGROUND INFORMATION

2.1 NNADAP Review General

The National Native Alcohol and Drug Abuse Program (NNADAP) is now in its fifteenth year of existence as the federal government's primary line of attack to combat alcohol and substance abuse in First Nations communities. As a successor to the less ambitious National Native Alcohol Abuse Program (NNAAP), NNADAP was designed to provide treatment, prevention, training and research services as a comprehensive federal strategy. The blueprint for today's NNADAP program is imbedded in the Cabinet discussion paper, which was submitted to Treasury Board in February 1982 and approved later that year on April 5. It was originally developed as a five-year $154 million program, and has gone through a life cycle which has seen a growth phase, a period of maturity, and more recently, a devolution of the program into community-based control.

The NNADAP evolved from a pilot project entitled the National Native Alcohol Abuse program, which was approved in December 1974 and was implemented over a three-year period beginning in fiscal year 1975-76. The purpose of the NNADAP program was "to support community designed and operated projects in the areas of alcohol abuse prevention, treatment and rehabilitation in order to arrest and reverse the present destructive physical, mental, social and economic trends."

The program was to provide a balanced professional, paraprofessional and administrative training program to support prevention, maintenance and treatment programs with a cadre of different level positions including advanced and basic level counselors. It was anticipated that this component would be carried out by Indian controlled "stations" as well as through contracted arrangements with established institutions. The document also referred to an accreditation program to maintain appropriate standards and consistency of service delivery.

Research and development support was to be carried out in order to increase the knowledge of the extent and nature of alcohol and substance abuse problems and the effectiveness of program approaches. Also acknowledged was the need for the development of case assessment, management procedures and practices. The issue of developing appropriate case assessment and management procedures and practices was referred to, as was the need for a national case record and information system to provide better monitoring and evaluation of individual cases and program effectiveness.

Within the program support elements discussed in the Treasury Board document, regionally based Indian and Inuit Institutions were envisioned which would offer local communities and organizations support through funding, technical assistance, training, research, planning, coordination and evaluation services. In the original discussion of program sequencing, it was felt that the first priority would be in establishing delivery capacity through Regional Indian Alcohol Commissions as well as the other support elements, such as training, research and development, followed by expansion of community projects and treatment programs. In this concept, multi-year agreements would have been developed with these commissions which would administer projects and provide necessary support to community projects.

2.2 NNADAP Design Elements

The program to replace the original NNAAP concepts was to include:

- Non-medical treatment services that were described as post detoxification primary care and counseling intended to focus on social and cultural rehabilitation. The treatment services are also described as involving intensive psychological and therapeutic counseling oriented toward social and cultural rehabilitation typically offered in a 28-day program. In examining potential program elements it was envisioned by the authors of the document that treatment elements would include inpatient residential treatment facilities, halfway houses and community-based (outpatient) treatment services.

- Prevention and maintenance activities including professional and paraprofessional counseling. It is pertinent that the original design of NNADAP Prevention and Maintenance programs included a wide range of activities including "advocative, educational and counseling services, provided on either a community-wide or on an individual case basis". The community services included "maintenance" which was to include counseling, self-help and individual and group therapy. The Treasury Board Submission also included reference to "complementary" services, which were to be targeted to family and friends of abusers. In discussing approaches, Alcoholics Anonymous and native cultural and spiritual practices were described as the range of anticipated services.

- Support activities such as training, research and development, organizational support, capital, and departmental operation and maintenance.

2.3 The Original Contextual Environment

The original National Native Alcohol Abuse Program was run as a joint initiative between Department of Indian and Northern Development and Health and Welfare (now known as Health Canada). The Discussion Paper on NNADAP presented by Ministers of National Health and Welfare and Indian Affairs and Northern Development dated February 17, 1982 described the tenuous nature of the program as having generally contributed to a sense of uncertainty among Bands and other participants concerning future funding. This impeded the development of effective support systems at local and national levels. It contributed to a high turnover of personnel, particularly at the community level. There were difficulties in negotiating ongoing funding arrangements with other levels of government and an overall lack of integration with the planning and implementation of comprehensive community socio-economic strategies. The authors drew this conclusion from their extensive consultation processes plus previous reviews including Linklater (1977), Hickling-Johnson (1979) and the Evaluation Core Group Report (1980).

The NNADAP program was implemented prior to government initiatives such as Community-Based Transfer under Health and Welfare, Native Economic Development (later labeled Pathways) by Canada Employment and Immigration Centers, and comprehensive Band Government legislation. Part of the rationale to proceed prior to the approval of these fundamental building elements appears to have been the relatively urgent and visible nature of alcohol and drug abuse among First Nations and Inuit people. This situation is evident from the concentration placed upon the nature, level, patterns, causes and consequences of Alcohol and Drug Abuse, which are carefully described in the NNADAP Discussion Paper.

The NNAAP and its successor program, NNADAP, had their roots in alcohol abuse programming. This is evident from the emphasis placed on dealing with alcohol abuse and is further reflected in the types of information describing the need for the program. There is mention of solvent abuse; however, this description is brief and it is not evident whether it was envisioned that this area of substance abuse was to be a focus for services.

Contribution agreements were used as the initial vehicle for approving funding to communities and organizations. Other funding mechanisms are now available for First Nations and Inuit communities to integrate and coordinate services and programs with alcohol and drug abuse, and any other priorities for that matter.

The NNADAP design did not include services which were considered to be medical in nature such as adult custodial care, detoxification, and trauma treatment, presumably since such services were considered by departmental officials to be services normally provided through the respective provincial health care system.

The program was also clearly not intended to address root causes and contributing factors of alcohol and drug abuse. However there was recognition that the NNADAP program required an emphasis upon leveraging other programs to improve conditions for First Nations and Inuit. There was funding provision for financial and technical assistance, which would promote functional linkages with federal programs and also to develop an integrated system of support drawing on community, provincial, private, and voluntary resources in addition to federal resources. Coordination of services was a considerable issue and focus for northern areas, since the population there is scattered in small pockets across a vast land base.

In discussing the targeting of services, there was mention made of isolated and less developed communities, adolescents and young working adults; urban migrants and women especially those with children or who are pregnant. However, there was more general recognition that all First Nation and Inuit groups face the problem of alcohol and drug abuse.

Major differences are evident between the current situation and the original contextual environment described in the NNADAP Discussion Paper. In 1981/82 there was not seen to be a mandate within Medical Services Branch for mental health services. There was not an understanding of the impact of residential schools upon the First Nations and Inuit population. There wasn't emphasis placed upon the issues of family violence and child sexual abuse. At the time, the NNADAP and the Community Health Representative program were the only programs to have First Nations health care workers available in the health field to deal with a wide array of problem areas. Furthermore, the NNADAP also preceded the development of First Nations managed Child and Family Services, which have become more available at the community level and which have changed the nature of staffing and the resulting levels of compensation offered at the community level.

In the opinion of the Review Team, the original plan outlined in the 1981/82 Discussion Paper presented a plan, which if it had been fully implemented, would have resulted in a much stronger program, than that which is currently available. To a degree, this preliminary blueprint remains useful in examining recommendations for strengthening program elements of the NNADAP in the future.

3.0 RESULTS OF THE NNADAP REVIEW

3.1 NNADAP Funding

The scope of this review includes regional and national expenditures on NNADAP over the time period 1983-84 to 1996-97 in the broad categories of treatment, prevention, training, research, management and support. It is impossible to reconstruct in detail, financial expenditures of the 1980s because different financial recording procedures were used compared to the present day. Therefore, for contribution expenditures of treatment, prevention and training in the 1980s, this review was provided with budgeted amounts rather than actual expenditures. Although actual expenditures in the management and support category were provided, a breakdown of these expenditures into operating and salary dollars was not available. Other limitations to this review include:

- There is not a separate accounting of capital expenditures provided, with the exception of 1990-91. Capital costs are likely included with general treatment expenditures, however some administrative expenditures could include capital.
- There is not a separate accounting for renovation

expenditures. Although this was a separate line item in the NNADAP plan set forward in 1982, the level of detail afforded this review precludes any analysis of the level of funding set aside or used to maintain the treatment center infrastructure.

- There is not a separate accounting for the regional commissions and national advisory board or the 1989 NNADAP review.

- Training expenditures were not separately coded in the regional aggregate activities for the time period 1983-84 to 1989-90. Also, in the 1990s, two regions incompletely coded training expenditures.

- As the scope of this review was limited to NNADAP, a more holistic look at the expenditures of all mental health programs and services under the mandate of Medical Services Branch (MSB) was not possible.

The NNADAP financial profile has been affected by two major events: the 1992 decentralization of funds to the regional offices of MSB, and the negotiation of transfer and integrated agreements which has further devolved program control to the community level. MSB headquarters retained the resources for research and development in the 1992 reorganization, and continues to play a consultative, policy setting role, as well as centralizing information resources, developing guidelines, standards and educational resources, and evaluating the program.

Four communities comprising the Nis'ga Health Board were the first to negotiate NNADAP transfer in 1988-89. Since that time to 1996-97, 95 agreements (transfer or integrated) have been struck involving 202 communities (see Table I below). Integrated agreements accounted for $1.7 million of NNADAP funds, and transfer agreements for an additional $6.7 million. These funds, which were formerly prevention and training resources in contribution agreements, are no longer included in aggregate totals for the NNADAP program. The transfer of two treatment centers has involved another $1.8 million.

TABLE 1

TRANSFER AND INTEGRATED NNADAP AGREEMENTS AS OF 1996/97

	INTEGRATED	TRANSFER	TOTAL

	No. of Agreements	No. of Communities	No. of Agreements	No. of Communities	No. of Agreements	No. of Communities
Atlantic	2	3	7	13	9	16
Quebec	3	3	14	16	17	19
Ontario	7	13	14	30	21	43
Man.	1	1	8	12	9	13
Sask.	3	3	18	42	21	45
Alberta	1	1	1	1	2	2
Pacific	7	15	9	49	16	64
Yukon	0	0	0	0	0	0
Total	24	39	71	163	95	202

The growth of NNADAP in the l980s, although significant, was not as large as the First Nations and Inuit Health Program overall. NNADAP experienced 41% growth from l985-86 to l990-91, largely as a result of transfers and integrated agreements; NNADAP had declined by 10.7%. The Community Health Activity of FNIHP, which includes NNADAP as one of the component, has also undergone significant transfer. However, there is an increase from l8.6% of the envelope to 27.1% between l990-91 and l995-96. In absolute terms, expenditures have more than doubled in this time period, in contrast to the decrease in NNADAP expenditures of l0.7% for the same time interval.

NNADAP has never experienced funding cutbacks in its fifteen-year history although research and development in particular has not been funded to the level that was planned. Extra funding was provided as part of the Community Workload Increase System ($2.8 million in l989-90) and to adjust for increased clients as a result of Bill C31, which granted status to First Nation persons ($9.3 million over 5 years).

As the program matured, the allocation of funding among the different components of NNADAP has varied throughout the fourteen years that were included in this review. Prior to NNADAP, the total budget in NNAAP was $8 million per year with prevention and training accounting for 75% of the budget and treatment a distant second at 13% of the budget. Program developers had projected that in 1985-86, prevention would decrease to 43% of the budget; however this target was not reached, and the prevention component still expended 58% of the total NNADAP budget. From 1985-86 to 1990-91 the total NNADAP expenditures increased from $35.1 million to $53.3 million. Treatment expenditures increased at the expense of prevention and training, from 35.5% of funds in 1985-86 to 42.9% in 1990-91. Prevention and training resources dropped to 44.2% of the budget. As transfer was not a significant variable in 1990-91, the increase in treatment resources can be attributed to enrichment in this component, and the completion of all the planned treatment centers.

In 1995-96, treatment costs claimed a larger share of the NNADAP envelope at 54.5%; however this is now more likely due to the emphasis placed on the transfer of prevention and training resources to the community compared to few transfers involving treatment center resources.

3.1.1 Treatment

Currently there are 49 treatment centers in NNADAP providing approximately 695 beds. It is difficult to obtain an up-to-date figure on the number of beds in the program as some treatment centers may have converted in-patient resources to outpatient spaces, closed beds or may operate provincially funded beds in the facility. The current level is 5% less than the projected total of 730 beds at program maturity (extra 590 beds were to be added to the 140 beds that existed in 1982). Reasons cited for not reaching this target relate to the increased emphasis placed on outpatient services and aftercare, a direction, which was supported by the recommendations of the 1989 national NNADAP review.

Nationally, treatment contributions were $6.4 million in 1983-84, increasing to $16.9 million in 1989-90. In the 1990s, treatment contributions continued to rise to $23.8 million in 1996-97. Annual per capita expenditures were stable, ranging from $38.02 to $38.95 per person, with the exception of 1994-95 ($34.42) when the Sagkeeng Treatment Center in Manitoba was transferred (removing approximately $2 million from the NNADAP envelope).

Some regions have covered per diem treatment costs of private treatment centers in addition to funding NNADAP centers, often through use of non-insured health benefits (NIHB). The practice of using NIHB resources in non-NNADAP centers was reviewed in 1995 at MSB headquarters. With the implementation of regional envelopes, the regions were notified that they were no longer able to charge NNADAP-type expenditures to NIHB. Regions were given the option of transferring resources out of NIHB to cover per diems at non-NNADAP centers but few took advantage of this option. This resulted in non-NNADAP operating expenditures dropping in 1996-97 to $689,980 from $2,638,890 a year earlier.

When compared to the level of treatment expenditures recommended by the NNADAP planners in 1982, actual per capita treatment expenditures have lagged behind. It was planned that in 1986-87, $71.50 per First Nation and Inuit person over the age of 15 would be expended on treatment[1] In actual fact, the per capita expenditures reached an estimated $56.03, which was 78.4% of that deemed necessary to meet demand. Not only was the actual amount of treatment expenditures less than that projected by the Cabinet document ($10.1 million[2] compared to $12.5 million), the eligible population aged 15 years and over was underestimated.

A similar calculation for 1995-96 of per capita treatment expenditures for persons over 15 years of age results in $80.83 for treatment expenditures in NNADAP. When presented in 1986 dollars to adjust for inflationary factors, the per capita amount is $59.60, which is 83.4% of the 1986-87 $71.50 benchmark.

A regional analysis of bed occupancy and use of additional resources (through NIHB or other operating dollars) shows that there is not a relationship between bed occupancy and increased use of private treatment centers. Regions with the lowest occupancy rates had the highest use of private treatment centers. This review has not conducted an in depth analysis of the issue to identify the reasons for this finding. Possible explanations include need for treatment services such as solvents and other special needs; the desire of clients to attend treatment centers close to home rather than travel to a NNADAP center; variability in the calculation of bed utilization rates; and inefficient utilization of the NNADAP centers' beds.

Treatment costs per client day are highly variable among the regions, and may be related to the size of treatment centers, geographic location, differences in programs offered, and differences in regional policies regarding contribution agreements. In the time period 1989-90 to 1995-96, the highest overall treatment costs per client day were seen in the Atlantic region, which had a mean of $213.18 for the seven years reviewed and the highest individual annual cost of $399.29 in 1991-92. The three prairie regions had the lowest client costs, with Manitoba realizing the lowest average cost of $75.33. Overall, the national daily treatment costs over this time period ranged from $121.14 to $159.52 with a mean of $138.47.

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[1] Based on the on-reserve population.

[2] The actual treatment expenditures recorded is $14.11 million, however capital costs are included in this total. These costs have been estimated at $4 million (see full text of report for description).

3.1.2 Prevention, Maintenance and Training

In NNADAP, expenditures for prevention and maintenance cover operating costs for a range of community information, advocacy, self-help, group therapy and crisis intervention services. In the NNADAP Cabinet paper, training was divided into two categories: staff development and ongoing refresher and orientation courses. No breakdown between these two components is available for the period 1983-84 to 1989-90. The expansion phase of the 1980s is reflected in the steady increase in regional funds accorded to prevention and training. These resources totaled $14.5 million in 1983-84, increased to $26.8 million in 1987-88 and ended the decade at $24.9 million.[2]

Prevention, maintenance and training expenditures were forecasted by NNADAP planners at $17.6 million in 1986-87 in a mature program. Using the on-reserve 15 years and older population which was predicted to be 175,000 persons for this year, the projected per capita expenditures in 1986-87 were $100.60 per person. The historical budget data provided to this review suggests that $25.9 million was expended in prevention and training in I986-87. Using the actual population, contribution expenditures in prevention and training were $130.62 per person, which was 29.9% higher than planned.

Prevention and training expenditures are itemized separately for the period 1990-91 to 1996-97. In 1990-91, prevention expenditures were $22.4 million and comprised 42% of NNADAP expenditures nationally. They peaked in 1992-93 at $27.4 million, and by 1996-97, decreased to $16.4 million or 37.4% of total NNADAP expenditures. At the regional level, all regions showed an increasing or stable level of prevention expenditures until the mid 1990s, at which time these expenditures started to fall, due to the negotiation of transfer and integrated agreements with communities. The effect of these transfer agreements on the *non-transferred* population remaining in the NNADAP funding envelope was examined by this review, by calculating the

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[3] This decline in funds at the end of the decade to 24.9 million (1989-90) is due to the transfer of resources to the Government of the Northwest Territories and to decreases in the FNIHP directorate.

regional per capita expenditures[1] for the years 1991-92 and 1995-96. 1991-92 was chosen because few transfers had occurred involving only 8% of the First Nations population. By 1995-96, the proportion of transferred communities had more than quadrupled to 35% nationally.

The regions vary greatly in individual per capita amounts for both years, due to the varying population sizes and the formula used to allocate funds whereby 25% of the available funds was distributed equally among all regions. For both years, a similar per capita spread among regions is obtained. For example, in 1995-96, the range was from Alberta's per capita allocation at $37.74 to $147.58 in the Atlantic regions. Analysis of the changes in the per capita amounts between 1991-92 and 1995-96 suggests that the per capita level of resources remaining after transfer in a region becomes proportionally larger. A potential explanation of this is the trend for larger communities or groups of communities to take transfer. This makes it appear that there is a higher per capita level of resources available after such transfers. As the prevention expenditures in the per capita calculation are solely contribution agreements and do not include regional management and support expenditures, the size of the remaining regional office during the transfer phase should not affect these per capita figures.

3.1.3 Research and Development

In the NNADAP Discussion Paper of 1982, research and development was listed as the fourth component, after treatment, prevention and training. It had been identified as a gap in the previous NNAAP demonstration project. Accordingly, the new NNADAP design incorporated funding for pure and applied research studies which were intended to add to the knowledge of substance abuse problems among Aboriginal people. This was intended to facilitate effective interventions and prevention strategies and the development of a national case record and information system, which would provide better monitoring and evaluation of individual cases as well as assessment of program effectiveness.

NNADAP budget forecasts incorporated a research component, calculated as 5% of the treatment and prevention/maintenance budgets on an annual basis. The research component would increase steadily from zero in year one of the strategy to approximately $1.5 million in year five.

Financial data shows an erratic approach to research and development, with

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[4] On and off reserve population from the Indian Register was used in the per capita calculation.

little attention attributed to this component in the 1980s. The decade of the nineties started out with approximately $400,000 as the annual research budget. The peak year for research and development was 1992-93 when almost $1 million was provided for projects and studies. A decision was made following the 1992 devolution of NNADAP funds to the regions to discontinue community-based research. The next three years averaged $600,000 annually, until 1996-97 when funding fell to just short of $100,000. On a percentage basis funding for research fell from a planning figure of 5% of the total base to .2%. This is 1/25 of the amount estimated in the original program design.

3.1.4 Management and Support

In the financial data provided for the 1980s, there is no breakdown between salary and operating costs in the category of management and support and two regions show incomplete expenditure data. The last year with complete regional information in that decade is 1987-88, which recorded a $2.6 million expenditure in management and support costs. In the period of the nineties, management and support expenditures have declined from $6.4 million in 1990-91 to $1.9 million in 1995-96. In 1996-97, these expenditures have increased by about 5% to $2.0 million from the previous year.

The pattern of salary expenditures in both headquarters and the regions for the time period 1990-91 to 1996-97 is variable. Despite the increasing number of transfers and integrated agreements, only Ontario, Atlantic and Pacific regions show a significant decrease of salary costs in the latter part of this time period. Saskatchewan, which had over 60% of its population under NNADAP transfer and integrated agreements by 1995-96, has had an increasing level of salary expenditures since 1991-92. Alberta, with essentially a non-transferred population, has had fairly stable salary expenditures. The reason for sustained salary expenditures even in a transfer environment may be due to regional policies which retain a full NNADAP position even if the NNADAP budget is reduced considerably, as NNADAP staff often have other responsibilities for related programs such as Brighter Futures.

In the FNIHP directorate, salary expenditures remained high from 1990-91 to 1994-95 at approximately $400,000 per year, even though only one full-time staff person was connected to the program during the latter part of this time period. With the discontinuation of the policy of dedicated staff for individual programs in the FNIHP Directorate, portions of many different staff positions make up a salary component of a program and it is impossible from these financial records to reconstruct the actual number of full time equivalents (FTEs) at headquarters that are associated with a program such as NNADAP.

In 1995-96, salary expenditures at the FNIHP Directorate decreased by approximately $360,000 to $75,672 and then bounced back to $279,196 in 1996-97. Nationally, salary levels decreased by 14% from 1990-91 to 1996-97, which is slightly less than the overall decrease in NNADAP expenditures (non-transferred) of 18% for the same time period.

TABLE 2

NUMBER OF NNADAP FULL TIME EQUIVALENTS (FTEs)
1983-84 TO 1996-97

	NNADAP FTEs	% of total FNIHP FTEs		NNADAP FTEs	% of total FNIHP FTEs
1983-84	37	1.5%	**1990-91**	34	1.8%
1984-85	54	2.1%	**1991-92**	28	1.5%
1985-86	60	2.4%	**1992-93**	28	1.4%
1986-87	51	2.2%	**1993-94**	65	3.4%
1987-88	50	2.2%	**1994-95**	36	1.9%
1988-89	38	2.0%	**1995-96**	30	1.6%
1989-90	35	1.8%	**1996-97**	*N/A	N/A

*N/A – Not available

As illustrated in Table 2 above, the number of FTEs associated with the entire NNADAP program has fluctuated among the years reviewed from 28 to 65, and the mid 1980s show the highest number of staff positions with the exception of 1993-94 which has 65 FTEs recorded. In the 1980s, an average of 2.0% of all FNIHP positions was attributed to NNADAP. This declines marginally to 1.9% in the 1990s (or 1.6% if 1993-94's high percentage of 3.4 is excluded) suggesting that the decrease of staffing in NNADAP overall is unremarkable when compared to other programs in FNIHP.

When salary and operating expenditures are considered together in the 1990s, a significant consistent decline is seen in contrast to the fluctuating levels seen with annual salary allocations. Nationally, salary and operating expenditures have decreased from a high of $3.2 million in 1991-92 to $1.8 million in 1996-97, a 43% drop. One-half of this decline relates to decreased expenditures in FNIHP directorate.

3.2 Stakeholder Expectations

The following information represents a summary of the team's findings with respect to the stakeholders views on various aspects of the NNADAP program that have been investigated as an element of the review. The findings and the draft recommendations represent the study teams view, which has been reached through the field study as well as through reviewing various information available through the mail surveys, the detailed studies, and the regional focus groups.

3.2.1 Perceptions on the level of addictions problems

Finding:

- ***There is recognition that various forms of addiction including alcohol, illegal drugs, prescription drug, bingo and gambling remains a serious problem at the community level.***

- ***The use of legally obtained and illegally produced or sold alcohol remains a major issue that affects the whole community.***

3.2.1.1 Alcohol

The various stakeholders rated alcohol abuse as the most serious addiction concern at the community level as shown in Table 3 below. This would indicate that although there has been considerable progress in dealing with this particular problem area, there is still a need to focus on services to communities in alcohol prevention, intervention and treatment. There needs to be a renewed focus and commitment, which comes both from Health Canada and First Nations to deal with the illegally produced or sold alcohol. This should be coordinated with law enforcement and crime prevention specialists.

TABLE 3

To what extent is the use of alcohol a problem in your community?

Respondent	Mean Score	Constant Problem	Frequent Problem	Combined Percentage
Leadership	4.2	40%	43%	83%
Health Service	4.3	46%	43%	89%
Social Services	4.4	51%	38%	89%
NNADAP	4.4	47%	43%	90%

*1 = not a problem 5 = constant problem

3.2.1.2 Illegal Drugs

Finding:

- ***The use of illegal drugs is a rising and pernicious concern at the community level.***

The use of illegal drugs is a growing concern as shown in Table 4 below. There are additional implications arising for the community in dealing with various elements of trafficking illegal drugs. During the site visits, particularly the youth indicated that the use of illegal drugs is extremely prevalent among adolescents and young adults. Of particular concern is the effect on the community and its various structures and services by the illegal "infrastructure" required to maintain a supply of such substances within the community. Consideration should be given to the establishment of a task force to examine means of dealing with the issue of illegal drugs. This task force could develop strategies to improve coordination, planning, and funding of community needs.

TABLE 4

To what extent is the use of illegal drugs a problem in your community?

Respondent	Mean Score	Constant	Frequent	Combined
Leadership	4.0	33%	38%	71%
Health Services	4.1	36%	42%	78%
Social Services	4.2	40%	40%	80%
NNADAP	4.2	43%	36%	79%

*1 = Not a problem 5 = Constant Problem

3.2.1.3 Bingo

Arising from the field visits and supported by mail survey results as shown in Table 5, is the issue of pervasive attendance at Bingo both on and adjacent to reserves. In most communities, Bingo is seen as a generally harmless recreational activity and as the primary means of supporting sports and other community programs. The problem associated with Bingo is the amount of time spent at these events, which takes away from time spent with family and in particular, children. It is important to capture the feelings of the youth on this subject, since there was frustration and anger that adults choose to spend considerable amounts of time at this activity, which in turn leave the youth without supervision at minimum, feeling neglected and abandoned in the worst case.

3.2.1.4 Prescription Drug Abuse

Finding

- ***The issue of prescription drug abuse should be examined.***

Other areas of addiction discussed in the field visits and the mail surveys indicate that the areas of prescription drug abuse and gambling follow use of alcohol and illegal drugs in terms of perceived level of problems, as shown in Table 5 below. It is interesting to note, however, that generally speaking the issue of prescription drug abuse was not well understood, and was not seen as a problem of the same nature as alcohol and drug abuse.

However, data obtained from Auditor General's Report on the Non-Insured Health Benefits indicates that prescription drug abuse is a serious concern in certain drug categories similar to solvent abuse. There are certain regions where the problem is more prevalent. A review of the delivery system and a thorough examination of this issue should be carried out. Also consideration should be given in devoting one or more centers to deal with prescription drug abuse and/or to provide training to communities.

3.2.1.5 Gambling

Finding:

- ***Gambling is an issue that is on the rise and should be dealt with before it becomes even more pervasive.***

In addition, according to discussions during the field visits, gambling was seen as an issue, which is on the rise. While gambling was not clearly an issue at first discussion, once interviewees began thinking about the issue and the different forms that gambling takes, then the seriousness and prevalence of gambling began to be recognized.

There should be an investigation of resources to determine incidence levels, to design appropriate information campaigns, and to provide necessary intervention and treatment services. Discussions should be held with provincial and national beneficiaries of various types of gambling such as lotteries, pull-tabs, and casinos.

3.2.1.6 Solvent Abuse

Solvent abuse, although ranking a lower mean score as shown in Table 5, remains an area of concern. The community visits reflected a variable and intermittent pattern of solvent abuse. The seriousness of effects of this abuse upon youth must be considered. This issue is discussed further in subsequent commentary.

TABLE 5

To what extent are bingo, prescription drug abuse, gambling, and solvent a problem within your community?

Respondents	**Bingo** Mean Score	**Prescription** Mean Score	**Gambling** Mean Score	**Solvents** Mean Score
Leadership	3.5	3.0	3.0	2.7
Health Services	3.7	3.2	3.2	2.8
Social Services	3.5	3.1	3.2	2.8
NNADAP	3.8	3.2	3.4	2.7

*1= Not a problem 5 = Constant Problem

3.2.1.7 Incidence and Prevalence Tracking

Health Canada should reinstate a structured research program that would provide a systematic means of tracking and anticipating patterns of addictive behavior. In developing this structured program there should be an implementation committee consisting of persons experienced in research from First Nation and Inuit communities and organizations such as the Alberta Addictions and Drug Abuse Commission. Further, Health Canada, First Nations and Inuit organizations should make a commitment to include addiction questions in the next phase of the First Nations longitudinal health survey.

3.2.2 Expectations for the NNADAP

Findings

- ***There is a high level of importance assigned to the program.***
- ***There are broad expectations that the Community NNADAP worker will provide services across the whole continuum of promotion, prevention, intervention, counseling and therapeutic services, and in aftercare and support.***

3.2.2.1 Importance of the program to the community

This high level of expectation was evident both from the field visit interviews with community leadership and from the mail surveys. In the mail survey, the leadership expressed the level of stated need for the program at a mean (or average) of 4.1 on a 5 point scale. Within the total number of leadership respondents for this question, 45% rated the program as extremely important and 34% rated the program as very important. This ranking is consistent with that of other community respondents as shown in the Table 6 below.

TABLE 6

How important is the NNADAP program
to the community members overall?

Respondents	Mean Score	Extremely Important	Very Important
Health	4.0	44%	25%
Social Services	4.2	51%	25%
NNADAP	4.2	48%	29%
Leadership	4.1	45%	34%

*1= Not important 5 = Extremely important

3.2.2.2 Expectation for program emphasis in prevention areas

Finding

- ***There should be a national social marketing strategy developed by Health Canada and First Nations and Inuit organizations to support program goals in prevention to correspond with the population health model.***

In examining whether there should be particular areas of program emphasis within NNADAP, leadership responses to the mail surveys did not place discernible patterns of preference either in promotion and prevention activities or in treatment activities. This is reflective of a general pattern of wide ranging expectations for the areas in which the NNADAP worker is expected to have an impact. Notable exceptions to this pattern of high expectations are two areas; developing policies for use and the regulation of alcohol and providing employee assistance program services to community members.

Examination of prevention activities, Table 7 below, the leadership respondents identify a consistent preference for activities targeted at the age group of adolescents to age 19, followed by children up to age 12. Services to young adults up to age 25 ranks third followed by services to adults over age 25.

TABLE 7

Please rate the level of emphasis that you feel should be placed upon the following areas within the NNADAP

Prevention Activities	Leadership Mean Score	Social Services Mean Score	Health Workers Mean Score	NNADAP Workers Mean Score
Developing policies for use or regulation of alcohol	3.7	3.5	3.5	2.9
Developing strategies to support healthy lifestyle	4.6	4.6	4.5	4.2
Carrying out educational activities in the school				
• Ages 5 – 8	4.1	4.1	4.4	3.7
• Ages 8 – 12	4.4	4.4	4.5	4.0
• Ages 13 - 19	4.6	4.5	4.6	4.1
Providing alternative environments and recreational activities				
• Children – age 12	4.6	4.1	4.3	3.9
• Adolescents –age 19	4.6	4.3	4.4	4.0
• Young adults – age 25	4.4	4.3	4.3	3.9
• Adults over 25	4.3	4.1	4.1	3.7
Providing Early intervention				
• Children - age 12	4.5	4.3	4.4	4.0
• Adolescent - age 19	4.6	4.4	4.6	4.0
• Young Adults – age 25	4.3	4.3	4.4	3.8
• Adults over 25	4.2	4.2	4.2	3.7
Conducting community Education campaigns				
• Local newspaper	4.1	4.0	4.2	3.5
• Community radio	3.4	3.5	3.6	2.8
• Workshops/speakers	4.5	4.4	4.5	4.1
• Written material	4.1	4.0	4.0	4.0
• Video	4.3	4.1	4.1	3.8
Networking with other providers At the local level				
• Brighter Futures	4.5	4.2	4.1	4.0
• Building Healthy Communities	4.5	4.3	4.2	4.0
• Mental Health Workers	4.5	4.4	4.4	3.9
• Child and Family Services	4.4	4.4	4.3	4.2
• Social Services/welfare	4.3	4.4	4.3	3.9
• Community Health Nurse	4.4	4.4	4.3	4.0
• CHR	4.3	4.3	4.4	4.0
Provide Employee Assistance Program Services to community	3.9	3.8	3.8	3.1

* 1 = No Emphasis 5 = Extreme Emphasis

3.2.2.3 Areas of treatment emphasis in communities

Finding

- **There should be revised scope of duties developed for the community workers to reflect expectations and realities of work carried out.**

- **Sample protocols should be developed to assist communities in dealing with the 24-hour requirements and means for handling on-call within communities.**

In addition to high expectations for services across a broad range of health promotion, prevention and intervention areas, leadership has expressed a similar high level of expectations for treatment services. By descending order of priority, the leadership ranked areas of activity in the Table 8 below that would be classified as treatment or treatment related services in the community. While this is useful to determine general areas of preference, the small degree of difference between activities renders it necessary to emphasize that areas within treatment have a high value assigned to them by leadership respondents. It is significant, however, that the highest value is assigned to activities to support sobriety, which may indicate that leadership recognizes this as a particular area of difficulty within NNADAP and thus to the First Nations and Inuit clients served by the program.

The levels reported by stakeholders in the section on prevalence of various addictive behaviors at the community level, rated use of illegal drugs as a close second to abuse of alcohol. However, given those respondents were adults who probably are not close to the drug use environment, the use of illegal drugs may be under-reported. Therefore, it would seem that it is recognized that there are some gaps in the program, which must be addressed to cover the areas of highest need in the community.

Community members raised concern about the community program workers' lack of follow-up to treatment services. They also raised concerns about the long waiting periods for persons wanting to attend residential treatment, and the lack of local options for treatment and detoxification services. Persons in treatment focus groups and community focus groups found that the cultural elements of treatment were most effective. Persons adopting traditional approaches to dealing with alcohol and drug abuse were seen as being more likely to succeed. Holistic models and using traditional tools such as healing circles were seen as desirable both at the community level and with treatment programs.

TABLE 8

Rate the level of emphasis that should be placed upon the following areas within NNADAP in your community
(Summary of Leadership responses on Treatment Areas)

Areas of Emphasis	*Mean Score	High Emphasis	Extreme Emphasis	Total Percent
Organize activities to support sobriety	4.7	13%	79%	92%
Coordination & Referral NNADAP Treatment Centers	4.5	30%	61%	91%
Coordination & Referral to other Native Treatment Centers	4.5	23%	65%	88%
Provide direct counseling to client families	4.5	19%	66%	85%
Check on clients during treatment	4.5	23%	66%	89%
Organize support groups in community	4.5	20%	68%	88%
Assessment of clients	4.4	27%	60%	87%
Coordinate & Referral to Detox Programs	4.4	26%	57%	83%
Coordination & Referral Specialized Treatment	4.4	29%	56%	85%
Follow-up on clients	4.4	21%	65%	86%
Follow-up at Six Months Or annual basis	4.4	22%	65%	87%

*By descending order of ranking (1= No emphasis 5 = Extreme Emphasis)

3.2.3 Coordination with other agencies

Finding

- ***There are real or perceived barriers to sharing of information and case working among the relevant providers.***
- ***There is a need and interest to network and to develop skills in cross-disciplinary areas***
- ***There are various organizational models that are effective***

When combining scores into one table, see Table 9 below, from all stakeholder respondents in the mail surveys, respondents gave highest ratings for the NNADAP to coordinate with Community Mental Health Workers. Second clusters of high ratings are for working with Child and Family Services, the Community Health Nurses, and Community Health Representatives. One variance to this pattern is that Leadership gave a higher rating to working with Brighter Futures and Building Healthy Communities than did social or health care workers.

As may be seen from the above summary of responses by stakeholders, there is a high degree of emphasis on networking between community based NNADAP workers and other workers within the community. In comparing expectations as outlined below in Table 9 with responses from NNADAP workers, it appears that the pattern of reported emphasis is slightly different. NNADAP Workers placed a greater emphasis on networking with child welfare workers.

Although not as clearly measurable, in the open-ended contributions from questionnaire respondents, there was frequent mention of the need to work with various law and justice agencies such as the Royal Canadian Mounted Police, band constables, and court workers. This information supports the previously expressed notion that the communities are concerned with the use of illegal drugs, the unauthorized selling of alcoholic beverages, and the interaction of individual clients with the legal system as a direct or indirect result of abuse of substances. There should be joint discussions with the Justice Department, Health Canada and First Nation and Inuit organizations to deal with illegal sale of alcohol and drugs and to solicit funding from crime prevention initiatives to combat the alcohol and drug abuse in the communities.

TABLE 9

Please rate the level of emphasis that should be placed on networking with other agency providers at the local level.

Agency Provider	Leadership Mean Score	Health Worker Mean Score	Social Worker Mean Score	NNADAP Worker Mean Score
Brighter Futures	4.5	4.1	4.2	4.2
Building Healthy Communities	4.5	4.2	4.3	4.0
Community Mental Health Workers	4.5	4.4	4.4	4.0
Child and Family Services Workers	4.4	4.3	4.4	4.0
Social Services Welfare	4.3	4.3	4.4	4.0
Community Health Nurse	4.4	4.3	4.4	3.9
Community Health Representative	4.3	4.4	4.3	3.9

* 1 = No Problem 5 = Frequent Problem

3.2.3.1 Treatment Centre Networking

Finding

- ***There is a lower degree of systematic networking and utilization of other health and social service provider in treatment centres.***

In contrast to the types of personnel utilized by community based personnel, treatment centers reported a different profile of use of personnel within the health and social services system (see table 10 below). It is significant to note that the mean scores of utilization expressed by respondents in the treatment centers are rated lower than those at the community level. This difference may be due to the more self-contained nature of inpatient residential programs. However, this rating also reflects the need for a concerted effort to put in place more systematic networking and utilization of outside personnel by NNADAP

Treatment Centers.

Effective program approaches should be multidisciplinary in nature. The reported use of psychologists by treatment center respondents is surprisingly low, given the nature of the work done by treatment centers, and given the general observation that family violence, and sexual abuse are prime causal factors. Better coordination with other providers is required.

TABLE 10

Frequency of utilization of various personnel by NNADAP Treatment Centers

Types of Personnel	*Mean
Elders	3.9
Traditional Healer	3.9
Physician	3.5
Community Health Nurse	3.1
Clinical Supervisor	3.0
Community Health	3.0
Psychologist	2.9
Nutritionist	2.7
Social Worker	2.6

* 1= Not at all 5 = Extremely Frequently

3.2.3.2 Effectiveness of networking activities

Finding:

- ***Networking with other health and social staff***

When the stakeholder respondents were asked to rate the degree to which NNADAP workers work **effectively** with other health and social staff in their community, the following table presents a useful comparison to those expectations.

TABLE 11

To what degree do your NNADAP Workers work effectively? with other health and social services in your community?

Respondents	*Mean Score
Leadership	3.9
Health Services Workers	3.5
Social Services Workers	3.7

*1 = Not at all effective 5 = To a great degree

Certainly, the point should be clear, that there are high expectations and real program requirements to network and coordinate with other health and social workers in the community, and that stakeholder views on the effectiveness of that coordination activity are not assessed as being at that same high level.

3.2.3.3 Context of Health and Social Programs

Alcohol, drug, and solvent abuse are a key element underlying many of the other problems faced by workers on reserves. Family violence, child sexual abuse, and many other aspects of issues faced by Child and Family services workers are related to abuse of alcohol and other substances. Health workers such as community health nurses and community health representatives are the first points of contact in many communities for any kind of health problem under which most community members would include addictions. Part of this preference is based on the history of programs in First Nations and Inuit communities in which nurses and CHR's were the first full time workers in communities available to deal with health and social issues.

In the last ten years, although not universally available across Canada, most provinces now have Child and Family Services workers who are directly employed by First Nations or Inuit organizations. DIAND funding approaches for Child Welfare requires a certain number of children needing care prior to forming an agency. Therefore many smaller combine with adjacent communities to form child and family service agencies.

In the last five years, there has been a gradual evolution of mental health programming within the areas of responsibility accepted by Health Canada. Psychologist, social worker and therapist services were primarily the resources used to address crisis and other mental health problems. Other community based funding including Brighter Futures and Building Healthy Communities programs were later introduced. Although Brighter Futures was originally designed as a national program focused on child development, it was acknowledged that general community mental health for aboriginal target groups was eligible through this funding. The Building Healthy Communities includes a mental health component, which is the largest of five components. Many elements within mental health workers' areas of responsibility such as health promotion elements, youth programming, healthy lifestyles, suicide intervention, and crisis response have direct and obvious relationships to alcohol and other substance abuse.

A further complication is that each of the workers described above may not develop annual work plans. Even if they do, they may not be shared with other workers. In general, there was a sense that communities in transfer had a management structure with clear lines of authority and management practices in place such as planning and evaluation. Generally, communities under contribution agreements do not have resources for management nor the flexibility to reallocate funds. Also there is less follow-up by Health Canada on support in meeting terms of the agreement. There are exceptions, however, and the Mohawk Council of Kahnawake while not under Transfer authority, has an addictions program design and management system that is extremely impressive and should be utilized as a model by other communities.

Similarly, the Rama First Nation, using a model derived from earlier work done by Hollow Water, had a case management model that similarly would be extremely useful for other communities to emulate. The model is also slightly different in that the NNADAP worker is part of the social services program rather than the health department of the community. The program features a central assessment process and referral to the appropriate service workers represented in a healing circle. It is interesting to note, however, that part of the assessment process determines the nature of service required and permits assignments according to such variables as sex or particular skills of the various workers. A release of information form is signed as part of the intake process, which assures smooth and ethical discussion of pertinent case issues. The other aspect of the healing circle approach used by this community, is the mutual support of workers thus preventing burnout, a problem faced by other communities.

3.2.3.4 Interest in joint training

Both mail survey and community visit interviews indicated a need and interest to network and to develop skills in cross-disciplinary areas. For example, workers in Health and Social Services expressed interest in training, which would promote effective approaches to address community needs, responding 80% and 79% respectively in favor of joint training.

3.2.3.5 Support to communities

Health Canada in a lead role with First Nations and Inuit organizations should conduct the necessary legal and programmatic research to develop standard protocols for release and sharing of information. There should be a particular focus on networking, information sharing, and protocols with social programs such as child and family services and social assistance programs.

There should be work plans and procedures developed to assist workers to focus on areas of need within communities. Health Canada and First Nations should develop strategic and annual priorities that will assist the program in providing necessary focus, leadership, and support to communities. In developing work plans and procedures, there needs to be particular emphasis on dealing with prevention, intervention and treatment strategies for adolescents and in coordinating with other health and social programs within the community.

3.2.4 Work in other related healing areas

Involvement in other areas of activity among NNADAP workers includes reported provision of services in grief and loss (3.8 mean score), depression (3.6 mean score), spousal abuse (3.5), victims of violence (3.5), sexual abuse (3.3) and offenders (3.3). Of particular interest is the rated involvement of NNADAP in tobacco, AIDS, and FAS/FAE programs. Significant numbers of NNADAP workers showed little or no service activities provided while in contrast other NNADAP workers indicated that there were high levels of program activity in these areas.

Similar to the points made above, there could be improvements in coordination and more effective services by developing a training strategy, which deals with these areas of common interest.

3.2.5 Effectiveness of community-based NNADAP Workers

Finding:

- ***There is generally a high level of commitment and dedication by the NNADAP workers both to the field of addictions and to the community.***

In any population there is a reality that there will be individuals lacking in commitment and dedication or in skills or in application of those skills. However, field visit interviewers saw an impressive number of workers who were both highly committed and effective. In the mail survey, effectiveness of NNADAP in meeting the needs of the community was rated as follows 8% as extremely effective; 22% as very effective and 34% as effective.

In spite of the general dedication of individuals working within the program, the NNADAP program is in need of improvement as reflected by the number of respondents (29%) who feel that the program is only somewhat effective, and by those who felt that the program was not effective (7%). It is worth noting that the Maritimes had the highest ratings while the lowest ratings (based on a scale 1 = not effective and 5 = extremely effective) were seen in Alberta (2.3), BC (2.7) and Ontario (2.8).

Part of the explanation for this may be related to the concerns raised about the level and availability of training and the need for a systematic approach to addictions programming. The workers in the Atlantic Provinces have had access to bachelor level training, which seems to have affected the level of scores. NNADAP workers have raised concerns regarding all aspect of training, particularly, with advanced and special training such as prevention, health promotion and community development.

All groups, stakeholders and workers alike, raised issues of credibility, recognition, and the need for support of the program from the national, regional, and local levels of management and leadership. The importance to have programs responsive to local needs was also pointed out. This included the need for effective communication and reporting to leadership, community members, networking with other health and social services personnel and using community resources to deal with addictions needs.

Several expectations of the NNADAP workers noted by leadership are the need to be available on a 24-hour basis, programs and services be available to all age groups and that services be provided in the related areas of family violence, spousal abuse, grief and loss, and FAS/FAE. In attempting to determine stakeholder priorities, which should serve as a focus within the NNADAP, it is an important observation that all areas of programming and target groups listed in the survey have generated high mean scores. This serves to underscore the observation that there are extremely high expectations for NNADAP workers and that those high expectations include a wide range of activities, which go beyond the boundaries of addictions programs. Obviously, such expectations are difficult to meet. While many of the identified areas are treatment in orientation, there needs to be recognition of the need to expand the focus in prevention and planning collaboratively with Brighter Futures program workers.

In addition to the above noted comments and concerns, the respondents' rating of the effectiveness of the NNADAP is not wholly directed to concerns of the effectiveness of the existing worker(s). This can be seen from comments in the section "How would you improve the NNADAP program" where responses related to the level of resources within the program, repeated concerns related to the need for full-time workers, and the need for workers to deal with both sexes. Addressing such issues are outside of the control of the NNADAP workers and must be addressed to the key decision-makers within First Nations and their organizations and Health Canada.

In the community visits, there were the predictable concerns with respect to the effectiveness of individual workers. Some of those concerns, however, relate to program design and support issues. For example, many community residents in focus groups indicate a need for the NNADAP worker to get out of the office and into the community. In a similar vein, the practice of requiring workers to be in the office from 9 to 5 every day conflicts with community demands. A significant part of the target group is in school or working during these hours, so workers need to organize activities in the evenings or weekends. In addition, community focus groups mentioned the desirability of focusing on seasonal approaches such as summer programs, which would capture periods of peak availability and boredom.

3.2.6 Use of land and traditional culture

There were frequent references to the need to incorporate use of the land and the environment, local traditions, native languages and resource persons such as elders into NNADAP programming. This is interesting in that the reported focus upon those elements both within community programs and treatment centers is surprisingly low.

Community leaders responded to the question, "Are you satisfied with the degree to which your alcohol and drug program has incorporated your tribal culture?" as follows: Not at all – 9%; Somewhat –15%; Satisfied – 35%: Very Satisfied – 22%; To a great Degree –19%.

The following table shows NNADAP workers' response on the use of native languages and spirituality in their programs:

TABLE 12

NNADAP Workers response on the degree native language and spirituality is provided in their program

Degree of Use	Does your program provide services in native language(s)?		Is spirituality part of your program?	
	Count	Percent	Count	Percent
Not at all	77	33%	12	5%
Hardly	33	15%	21	9%
Occasionally	36	16%	50	22%
Frequently	24	11%	58	26%
Primary language of service extremely frequently	57	25%	86	38%

The impact of these ratings however, has to be considered in light of responses to the next question. Here 179 respondents (75%) stated that they utilized traditional aboriginal beliefs as describing the type of spirituality rated in the above question.

Considering the degree of importance, which is generally allocated to incorporation of traditional practices within NNADAP programs the self reported rating for use of various aspects of traditional culture might be considered low.

TABLE 13

NNADAP Workers response to the use of various aspects of traditional culture

Aspects Of Traditional Culture	*Mean Score
Elder's teachings	3.7
Local culture and practices	3.7
Traditional spiritual practices	3.4
Language	3.3
Traditional Child rearing	3.0
Crafts and Clothing	3.0

**1= no emphasis and 5 = extreme emphasis*

3.3 Related Concerns

3.3.1 Privacy and Confidentiality

Finding:

- ***In some situations, administrative offices and Health Centers as currently configured were not conducive to provision of addiction services either to individuals or groups.***

Field visit interviewers found that the NNADAP workers were affected to a large degree by perceptions regarding confidentiality. There are many aspects to this issue, which bear further examination. For example, in a majority of workplaces observed during field visits, there was a considerable degree of difficulty in accessing space for confidential interviews. In general, there was a frequent degree of interruption, phone calls, relaying messages while counselor was with client, and other examples which would not instill confidence in clients that they are important and that their issue remains private. Health Canada should take a lead role in collaboration with a steering committee of stakeholders to develop facility models, which would enhance client perception of confidentiality. This concern is also related to similar requirements associated with program initiatives in mental health, child welfare, and social services. Part of the study should identify costs to make facility, equipment, or office furniture modifications for ensuring confidentiality.

There was also a general preference for clients to have a counselor available who is of the same sex. In communities where there were only female counselors, for example, it was felt that there should be a male available for certain populations who would feel that they could only discuss certain elements of their problems with another male, and vice versa. This is supported by the expectation that NNADAP workers provide services in areas of family violence and sexual abuse, which are laden with gender issues. Consideration should be given in developing a code of conduct for NNADAP workers, which could be posted in First Nation buildings and in NNADAP offices. This would outline expectations relating to confidentiality, obligations, possible remedies and penalties where there are violations. This could be achieved through a working group of stakeholders.

Treatment Center respondents had a slightly different profile for describing the adequacy of treatment facilities (see Table 14 below). Differences in the overall status of treatment facilities may be due to the fact that not all regions of Health Canada operation consider the NNADAP treatment programs to be part of its overall capital and maintenance programs. The Wanaki Lodge, for example, in Quebec region had a well-maintained facility that had discernible improvements since its original construction including additional garage space, a "gazebo" for better use of the multi-seasonal operation of the facility. This, of course, should also be attributed to the pride and care taken in the facility by the treatment center staff. A similar observation was made at the Tommy Beardy Memorial Center in Northern Ontario where the facility was in a similar, well-maintained condition.

TABLE 14

Adequacy of office space and facility

Description of office space and facility	NNADAP Workers response to office space		Treatment Centers response to facility	
	Count	Percent	Count	Percent
Below standard and unsuitable	32	16%	1	6%
Below standard and barely suitable	24	12%	12	75%
At standard but could use improvement	102	49%	–	–

At standard for providing service	47	23%	3	19%

3.3.2 Impacts of Transfer

Transfer policy is a key element of federal policy and is reflective of the Indian Health Policy. While transfer is optional for First Nations, the pace will continue to grow in the future. Furthermore, communities are moving from transfer agreements into Flexible Transfer Agreements or Self-Government Agreements.

Transfer policy must now fit into the broader context of implementation of Royal Commission on Aboriginal Peoples (RCAP) recommendations. These recommendations detail approaches to fundamentally change the way governments and First Nation communities will do business. Most recently the federal policy, "Gathering Strength", Canada's Aboriginal Action Plan provides a framework for the federal government to make RCAP recommendations part of the agenda for Canadians and Indian and Inuit communities. A Healing fund has been set up which is viewed by many as a significant component of a holistic initiative to address the problems of mind/body and spirit.

Transfer policy has provided a great deal of opportunity and flexibility for communities to do needed work to address health problems. NNADAP and addiction programs continue to be one of the key needs in the communities visited. In transfer communities, it was observed that resources provided by NNADAP were combined with other resources as Brighter Futures, Building Healthy communities, to provide adequate funding for a combination of programming and services. In most transferred communities, NNADAP maintained its own identity and works closely with other local service agencies to provide appropriate services.

In community visits and surveys the responses regarding transfer were quite positive. Both leaders and NNADAP treatment Centers indicated the need to consider transfer. Sixty six percent of responses from leaders and seventy one percent of treatment Centers indicated a willingness to transfer. Interesting, these views were not shared with the NNADAP workers as twenty-four percent indicated a willingness to consider transfer.

A factor which may have influenced different stakeholders was a lack of understanding of the type of agreement that the community was under at the time. Leaders were at times unaware of the type of agreement that covered them. For example, leaders and NNADAP workers survey respondents differed on the understanding of which type of agreement was in place. In most instances, the workers understanding were accurate.

TABLE 15

What type of agreement is your community under?

Type of Agreement	Leaders %age yes	Workers %age yes
Contribution	91	55
Health Transfer Agreement	36	33
Alternate Funding Arrangement	21	8
Flexible Transfer Agreement	18	8

*Percentages do not add up to 100% since respondents could identify more than one type of agreement.

Responses indicate the variable interest on the potential implication of different types of agreements. In the case of treatment centers, only two types of agreements were identified contributions and health transfer. Treatment Centers responses indicated seventy one percent of Centers were willing to consider putting themselves under transfer.

In transfer communities, the additional administration and management resources allowed for the creation of a management and planning structure for the community. The creation of a community health plan provided a systematic approach to address community needs. Some communities visited have redesigned programming under NNADAP to be part of a health team, providing a range of direct services to the community. In one Northern Community, Health Workers with specialties such as addiction/ nutrition/public health, etc. developed well planned, consistent and effective services. A key to the long term success of NNADAP elements in transfer is being part of a community health plan and and being able to measure daily, monthly and yearly progress. In transfer communities, this has enabled workers at the community level to measure achievements and to show tangible results.

A majority of community respondents felt that there were few drawbacks to transfer. However, the fear is that transition from a NNADAP project to a transfer agreement will detract from the focus on addictions.

As with federal transfer agreements, the development of evaluation outcome data and results measures of services become paramount to rationalize choices, decisions or justification of funds to provide a specific set of addiction service measures.

3.3.3 Federal - Provincial Relations

A key assumption made in the design of the NNADAP was the recognition that other health services as detox, mental health, etc. would be provided by provinces. Due to the extended period of deficit fighting, reduced national/provincial spending on health care costs has created gaps in the health care system.

Various provinces have undergone health reform in different ways which has caused changes in the health care services provided in each respective province. Relative erosion of addiction services is one of the fallouts of reduced health care spending and revised priorities with provincial health care systems. This change in health care systems has impacted First Nations and Inuit communities.

In Atlantic Canada, visits and focus groups raised concern on the lack of availability of treatment beds and detox services. Historically, linkages to the provincial health care system are viewed with scepticism by many First Nations. Therefore, the extent that the provincial health care system is part of a strategy for programming in First Nations and Inuit communities varies.

Quality of interaction between NNADAP projects and treatment facilities and provincial services also varies. NNADAP centers/projects report receiving various levels of assistance from provincial programs, most notably British Columbia, Alberta and Ontario.

For centers, questionnaire responses indicate the level of coordination with the levels of government was very little to non-existent as may be seen from Table 16.

TABLE 16

Coordination with other levels of government as rated by Treatment Centers

Government Levels of Coordination	Not at All	2	3	4	To a Great Degree
Municipal	8 (47%)	2 (12%)	2 (12%)	4 (24%)	1 (6%)
Provincial	5 (26%)	4 (21%)	6 (32%)	3 (16%)	1 (5%)
Federal	5 (26%)	3 (16%)	4 (21%)	5 (26%)	2 (11%)

Out of 17 treatment centers that responded, ten have rated their level of coordination with municipal government at "not at all" or "limited". Nine out of nineteen Centers responded "not at all" or "limited" when rating on the degree of coordination with the province. To a degree this is attributable to the stand-alone nature of existing treatment programs. However, given the necessity to utilize detoxification services that generally fall under provincial or municipal jurisdictions, this represents an area for considerable improvement.

For NNADAP workers who are key providers of services in communities, the level of coordination is higher, please see Table 17. This is to be expected given the need for more local coordination. However, given the assumptions of the Treasury Board Submission establishing NNADAP, provincial and municipal coordination is an area which also requires significant attention. Thirty-three percent of NNADAP respondents noted a good to high degree of coordination with the provincial levels of government. The agencies identified included detoxification services, provincial hospitals and other social agencies.

TABLE 17

Coordination of programs with other level of government as rated by NNADAP workers

Government Levels of Coordination	Not at All	2	3	4	To a Great Degree
Municipal	70 (39%)	30 (17%)	23 (13%)	28 (16%)	30 (17%)
Provincial	58 (28%)	36 (18%)	44 (21%)	39 (19%)	29 (14%)
Federal	57 (29%	31 (16%)	37 (19%)	39 (20%	31 (16%)

3.4 Specific Treatment Center Findings

3.4.1 General

One of the most rewarding experiences of the NNADAP Review were the visits to the treatment centers. Just as individuals are unique and different, so are the treatment centers. Their uniqueness lies not just in their cultural differences, but also their physical and environmental space, the staff they have, and the many different types of psycho-educational experiences they provide to their clients.

Most treatment centers are incorporated societies with direct reporting to political organizations of First Nations. The majority of treatment centers are moving under Transfer. Most see Transfer as a positive experience and feel that Transfer has allowed them more flexibility in how they use their budgets. Another benefit many felt was that Transfer would give them long term stability. One treatment director did caution us at a regional meeting that Transfer has risks if the health authority decides that residential treatment dollars could be used for other purposes.

Most of the treatment centers do not use native language in their programs. They do use native language for those clients that can only speak in their native language. Traditional aboriginal beliefs are practised in all the treatment centers. Most of the treatment centers serve traditional foods with varying frequency and availability.

Intake patterns vary from treatment center to treatment center. Some centers have daily intakes, some do weekly intakes, others doing bi-weekly intakes, and some centers do treatment cycle intakes. Treatment program length averaged five to six weeks at most centers. Very few of the treatment centers had programs of four weeks or less in length of programs. Many of the treatment centers allow clients to stay longer than the treatment cycle. The rationale for keeping clients past the treatment cycle length was most commonly explained as "the client needed more time". This practise of keeping some clients past the normal treatment cycle length is good practise and shows sensitivity to individual client needs.

Some of the common elements found in all the treatment center programs were (a) one-to- one counseling; (b) large group experiences; (c) small group sessions; (d) native spirituality; (e) heavy reliance on the use of abstinence models and AA philosophy; (f) heavy educational emphasis; (g) counseling staff who are in recovery themselves. Differences between the treatment centers were found in emphasis placed on the eight elements except for cultural practises and beliefs, and treatment staff competencies. The one-to-one counseling, while having value, needs to be examined when this is featured as the primary treatment methodology. This is because the value of residential treatment is in the development of "community" and "treatment intensity". Clients that rely on the one-to one experience tend not to depend on the community for their learning and growth. They deny themselves the experience of learning important social skills such as interpersonal trust, which they need to learn for successful recovery. This practice also has the potential of taking away from the client group the building of "community".

The Review found that the majority of staff in treatment centers are in recovery. Advantages to having staff who are in recovery are their ability to be empathic with their clients and to identify and understand the experience clients are going though. The risk, especially if all the staff subscribe to one model of recovery only, is that they may prevent clients they are working with to access other roads to recovery. There are many roads to recovery, and many models of addiction that clients need to hear about. There is no "only one way" or "program".

Another finding the Review team found concerning treatment-counseling staff was in their qualifications. Some of the common elements in all the job descriptions were: must have sobriety that ranged from six months to two years, grade XII minimum, and good communication and writing skills. Many of the job descriptions did ask for post secondary, especially in the areas of addictions training. Most of the treatment centers expressed problems recruiting qualified staff. When asked, "how come?" low salaries paid to counselors was the reason most often given.
Qualifications of counseling staff varied from treatment center to treatment center. The qualifications of counseling staff presently working in the treatment centers averaged on the low side. It is important to mention here that though the centers are having difficulty recruiting qualified staff, the staff they do have are effective. We found that the majority of treatment centers place a lot of energy in the in-house training of staff. They often send many of their staff to workshops that are in their area, and are very supportive to all sorts of staff development opportunities. During our interviews with the staff we were impressed with their commitment to learn, their loyalty and belief in the clients they work with, and the ethical reasons they gave us for working in this field.

The Review Team was also impressed with the administrative structure of the programs. All the treatment centers had policy and procedure manuals, had good record keeping practises, had admission and discharge policies for clients, were knowledgeable of federal and provincial regulations regarding the Privacy Act, the Freedom of Information Act, and the reporting of child abuse and neglect. Staff supervision was available in all the treatment centers. Depending on the size of the center the Director of the treatment center was usually the one responsible for all supervision.

One of the treatment centers that should be mentioned for its innovationand quality is the Round Lake Treatment Center. This is a 36-bed residential treatment facility for alcohol and drug dependent adults over 17 years of age, who are of First Nations descent. The Center is located in the interior of B.C. on the Okanagan reserve, near Armstrong, B.C. Since its opening in 1978, Round Lake has received over 5,000 clients from all areas of the province. The Center is governed by an elected twelve member Board of Directors known as the Interior Native Alcohol and Drug Abuse Society. The Center deals with many issues of addiction and trauma that are interrelated with substance abuse, such as sexual abuse, and residential school trauma.

Over the past fifteen years, Round Lake has continually maintained a leadership role in the development and delivery of treatment programs for substance abuse and other related issues. A client outcome study in 1987 lead to significant changes in program operations that resulted in development of improved pre-treatment or readiness programs to better prepare individuals for intensive residential treatment. Changes were also made in treatment approaches and in the cultural program to accommodate First Nations people from all parts of the province. Over the five-year period from 1991 to 1995, Round Lake admitted 1,473 clients of whom 75.5% completed treatment. A recent 1996 "client outcome study" estimated that 87% of completions were clean and sober at three months after discharge from treatment; 69% at one year, and 65% at two years.
Its program philosophy of "Culture is Treatment" is the foundation of the work carried out locally, regionally and nationally. The program is based on the holistic concept of the Medicine Wheel, which includes the spiritual, emotional, mental, and physical aspects of life. It is this important healing and life tool that Round Lake shares with those who join the healing circle with the goal of being alcohol and drug free.

The Mission Statement of the Round Lake Treatment Center is facilitating ***personal wellness of First Nations people by providing culturally specific treatment and training services.*** This mission statement is supported by the following goals:

- To deliver an accredited First Nations training program.
- To develop and implement programs to involve the family in prevention, intervention and treatment
- To keep high-quality and innovative, in-patient and

community based treatment and treatment services.

- To coordinate and network with First Nations people and government agencies to implement positive leadership through the development of effective treatment programs.

The Round Lake program consists of individual, couples and group counseling sessions; individualized treatment plans based on client goals; educational teachings on all aspects of addictions and related behaviors; development of First Nations spirituality and cultural awareness through the use of traditional teachings and ceremonies; physical fitness promotion through nutrition education, aerobic exercise and regularly scheduled recreational activities; confidential HIV/AIDS surveillance programs; and medical, psychological and other professional services.

Some of the distinctive qualities of the Round Lake Treatment Center are summarized in the following statements:

- The Center is housed in very beautiful and comfortable buildings in an aesthetic location.
- High quality (meeting accreditation standards) of program and organizational systems.
- Does continuous improvement of program methods

- Clients can feel they have a common bond, sense of belonging and clients-staff-board share a common history and understanding
- Promotion of First Nation cultural values, principles and practices, including the utilization of elders as teachers, as cultural/advisors and as spiritual guides
- Good ability to provide specific programs for specific target groups to meet larger community needs
- Operate from a strong code of ethics
- Offer client focused services
- Provide community training
- Has substantially changed their model of treatment from a disease model to cultural and post trauma and health restoration.

- Has a visiting doctor and psychologist
- Has a nutrition based program for 11 years as part of the education process
- Has a strong recreation program
- Engages staff in a regular review of programs and in the redesign of programs in response to the review
- Center staff are active members of the British Columbia Aboriginal Treatment Directors Association
- Center is member of an international agreement to develop healthy communities.

3.4.2 Treatment Center Capacity and Funding

The following contains the results gathered from the field surveys and mail in questionnaires received from treatment centers across Canada. A total of 19 mail in questionnaires was received and 5 field surveys were undertaken. They contribute to the following results and recommendations.

Treatment center bed capacity ranged from a high of 40 to a low of 5 based on the returned survey results. The majority of treatment centers ranged in the 10 to 20 bed capacity. Most of the treatment centers are 100% funded by MSB. Several of the centers reported receiving some provincial funding that ranged from 2 to 18 beds. The majority of treatment centers reported that they have additional beds that they are not funded for, but they use them for additional client services and/or to meet their maximum patient days. Many of the treatment directors reported feeling that they had to play a numbers game with MSB because funding was based on per diem usage. None of the treatment center directors reported they used unfunded beds to increase revenue for their center but rather to compensate for low intake periods and/or clients that drop out of the program early.

3.4.3 Outpatient Capacity

Finding

- ***Based on creative and valuable use of outpatient funding, treatment centers have shown that new funds for outpatient services will result in valuable program development.***

The review found that about 50% of the treatment centers were federally funded for providing some outpatient services and/or beds. Those centers not receiving funds for outpatient services expressed a strong interest in a similar arrangement. The Centers with funding offered a variety of different services. For example, one center used its funds to provide services to women; another center used its funds to provide outreach services, another center provided direct counseling for families in communities, and another center used its funds to put a worker in different communities for the purpose of helping the communities prepare their people for residential treatment.

3.4.4 Primary Client Groups

Finding

- ***There is a lack of treatment services for children, youth and families.***

The majority of the residential treatment centers work primarily with adults. Many of the treatment centers are now offering gender specific and treatment specific programs within the adult population such as women's only programs, men's only programs, and survivors of trauma programs. Most of the centers work minimally with youth and family for a variety of very legitimate reasons that are related to funding, facility design, and training of workers. Based on the Review findings, the ranked order of groups served are men and women with services for families, elders, youth and adolescents. Other population groups such as gay/lesbian, handicapped/disabled and FAS/FAE were not a focus for service. The review team found from the field visits that the treatment centers were frequently requested to provide treatment services for youth.

Findings from the mail questionnaire and field visits found great concern being expressed for the lack of treatment services for children, youth and families. To compensate for the lack of services many communities have developed programs that are seasonal (summer) directed specifically towards youth and family. These programs are often referred to as “cultural awareness camps” most commonly located on traditional territory. The elders and volunteers are heavily used to help deliver programs in these camps since funding for staff is minimal. Because of the unique training and skills that residential counselors possess, treatment centers should consider reorienting their summer programs to assist in the delivery of programs carried out in their area cultural camps. Treatment centers should not be penalized for delivering programs in cultural camps.

Models should be developed for "couples" treatment. This would be a practical alternative to family treatment, which would eliminate complications arising from having multiple age groups and family units in programs.

3.4.5 Financial

Finding:

- ***Treatment centers do not have national standards, and lack quality assurance programs***

One of the questions asked of the residential services was "*Please rate the importance of the following factors when considering what should be considered by MSB when developing funding allocations and processes?*" Based on the findings shown in the Table 18, actual costs ranked as being most important, followed by effectiveness, efficiency, size of center, type of treatment, degree of isolation and outpatient services. Though all factors were rated extremely important, actual costs ranked number one, which indicates that the majority of centers are struggling to keep costs within their funding allotments. Effectiveness and efficiency ranked 2 and 3 respectively in importance.

Without national standards, and with the lack of quality assurance programs that exist in the NNADAP programs, it is difficult to interpret these results. These two findings do suggest that the majority of centers feel that they operate lean, quality, effective programs and therefore should be recognized with appropriate funding. Degree of isolation was extremely important for those centers that are isolated. The score in Table 18 for this factor has been skewed by those centers that are not isolated.

Because the scores in Table 18 are aggregate counts in percentage, it is difficult to interpret "type of treatment" and "size of treatment center". For example, centers offering programs for youth will incur significantly higher costs than adult based programs making this factor more important than it would be for those centers that do not offer youth programs.

TABLE 18

Factors that should be considered by MSB when developing funding allocations and processes

Type of Factor	1	2	3	4	5	*Mean Score
Degree of isolation	6%	–	17%	33%	44%	4.1
Size of Center	–	5%	10%	30%	35%	4.4
Actual Costs	–	–	–	26%	74%	4.7
Outpatient Services	6%	6%	12%	29%	47%	4.1
Efficiency	–	–	–	37%	63%	4.6
Effectiveness	–	–	–	32%	68%	4.7
Type of Treatment	–	–	21%	32%	47%	4.3

**1=not important and 5=extremely important*

Table 19 gives the result from the question that asked, "*Please rate the importance of the following funding mechanisms in terms of how important they would be for enhancing the operation of your treatment center?*" Effectiveness and efficiency ranked one and two respectively followed by flexible funding, core funding, and per bed rates. At present there are no mechanisms in place nationally for measuring effectiveness and efficiency and for comparing these factors with other peer centers. Yet the treatment centers place a very high value on these two factors. Per bed rates ranked last but maintained a high mean score. This response would suggest further support for the treatment centers placing greater importance on efficiency and effectiveness than per bed rates and core funding.

Treatment centers are concerned with the present arrangements and want other factors to contribute to their funding levels. Most notably, actual costs, isolation, efficiency and effectiveness ought to be used for determining funding levels. Health Canada should review its present funding formula process and factor in isolation, actual cost, effectiveness and efficiency to ensure they are equitable with other professionals who work in parallel programs such as the provincial addictions agencies. It is further suggested that such increases should be associated with the attainment of standards or accreditation and maintaining this accreditation.

Health Canada and First Nations and Inuit organizations should examine means by which treatment center budgets could be increased. Additional resources are needed to provide orientation to health and social NNADAP referral agents, annual training budget and treatment in grief and loss, cultural programs, and in treating other emerging addiction areas such as gambling, prescription drug abuse. This could be achieved by Health Canada playing a coordinating and facilitating role in determining opportunities to supplement funding from other sources including provincial and other federal departments for NNADAP treatment centers.

TABLE 19

Please rate the importance of the following funding mechanisms in terms of how important they would be in enhancing the operation of your treatment center

Type of funding mechanisms	1	2	3	4	5	Mean Score
Per bed rates	5%	25%	15%	15%	44%	3.6
Core funding	5%	–	21%	32%	42%	4.1
Efficiency rewards	5%	–	–	40%	55%	4.4

Effectiveness	5%	–	–	35%	60%	4.5

1=not important and 5=extremely important

3.4.6 Addiction Models

The table 20 below shows the results from the mail surveys on the question on models of addiction used.

TABLE 20

What models of addiction do you use in your approach to working with others?

Type of Model	Count and % using Model	
Disease Model	16	(84%)
Bio/psycho/social	7	(37%)
Behavioral	9	(47%)
Environmental	5	(26%)
Genetic	3	(16%)
Social/learned	8	(42%)
Moral	4	(21%)

Comparing these results with the field visit responses showed almost identical use in the different models. Some of the centers in the field visits also reported doing recreation and exercise as part of their therapeutic approaches. Most of the treatment centers place the heaviest emphasis on 12 step AA and/or disease models. The community visits revealed poor post treatment, aftercare, and support, and raises question about the relevance of the disease model and the 12-step approach. Most centers use the cultural model but do not identify it as such due to the reality that cultural programming is seen as a way of life, not a model. Combined with this is the fact that many of the clients that attend residential treatment arrive with a wide array of mental pain brought on by abuse, violence, residential school effects, and grief and loss.

Each of the models listed in the above Table 20 has limitations. New research and treatment methodologies are presently available that are less defined, less dogmatic, and better suited for helping clients take control over their own lives. It would appear that the majority of treatment centers use a variety of models to reach a wider client type. However, treatment centers need to keep abreast of the research and develop new approaches to helping clients deal with their problems and place less reliance on disease models of addiction. The need for multi-disciplinary programming is supported by previously cited findings in the Review that showed emphasis requested by stakeholders as follows on a scale of 1 to 5 (1= no emphasis desired and 5 = extreme emphasis desired); 3.8 mean score for grief and loss issues, 3.6 for depression, 3.5 for dealing with spouse abuse, 3.5 for victims of violence, 3.3 for sexual abuse and 3.3 for offenders.

Access to training and available monies for training is very limited in most treatment centers. Residential treatment is for the most part tertiary in nature. Because clients often present themselves with a variety of mental health problems including addiction at residential treatment, it would make sense that counseling staff has access to information and current research trends. This can be easily accomplished through the use of the Internet. However, staff training is far more expensive yet critical. Abstinence does not remove psychic pain. If our intention at residential treatment is solely abstinence then failure rates and recidivism will remain high. If we can help our clients understand the sources of their pain and take control over their own lives, success at abstinence will be much higher.

3.4.7 Client Catchment Areas

Based on the respondents' self report, most clients referred to a given center are from the province where the center is located at 75%, followed by 48% from the immediate catchment area, and 23% from the nearest community to their community.

3.4.8 Cultural Programs

First Nations treatment centers differ from their mainstream counter parts in their use of First Nations culture. Most of the treatment centers introduce native culture as a major tool for a native person's sobriety and recovery. Awareness of native spirituality and culture is taught to the clients to build inner strength, develop a positive self-image and regain a respect for self and all living things. This process is also considered by many of the treatment centers as a holistic approach to the healing process that brings about stability, harmony and balance in their clients' lives.

The clients surveyed indicated the strength of the cultural activities in their recovery, which contributed to cultural growth and personal development. Each treatment center has its own unique activities that are common with the culture in their area. However, many of the activities have some similarity and commonalties such as:

- Participation in sweat lodge ceremonies
- Participation in smudge ceremonies
- Conducting group sessions with cultural resources
- Participation of elders in the program
- Participation of native spiritual advisors in group and one-to-one sessions
- Teachings of the medicine wheel in many of the centers
- Daily prayers and singing of traditional songs by staff and/or clients
- Drumming and singing used to introduce ceremony and/or as daily practise
- Clients are invited for cultural activities in surrounding communities of the treatment center
- Delivery of teachings and lectures by the counseling staff has a cultural awareness component embedded in the process, that promotes individual spiritual development.

In client treatment focus groups, it is interesting to note that the cultural elements were deemed to be most useful to participants. It is also interesting to note that while the local culture was preferred, if another native culture and cultural practices were taught, it was still seen as being of value to the client. It was also noted that at the beginning of treatment, the cultural element of treatment was not always appreciated. This would imply that orientation to treatment should deal with the cultural issues and that consideration be given to advanced treatment. This would have a focus on cultural healing.

Anecdotally, it would seem that many individuals seeking treatment have experienced cultural alienation as a key element of their personal problems. This is consistent with research in cross-cultural education, which has indicated that individuals who have been assimilated and have lost values of culture and language have many health and social problems. Individuals who have retained their culture and language can be integrated with the dominant culture without being lost in it.

3.4.9 Client Discharges

One of the trends that the Review Team studied were reasons for early discharges of clients from residential treatment centers. The findings showed that the largest majority of early discharges of clients were because of poor preparation and lack of readiness for treatment. This was followed by self-discharge of clients due to family or other outside factors such as death of a relative or family member. The third most common reason for clients leaving early was stated as the "inability of clients to follow institutional rules and policies". Ranked fourth was "unsuitability of client to the program" which can also be interpreted to mean inappropriate referrals. Ranked last was "clients use of alcohol and/or drugs". Further corroboration for the early discharge pattern was obtained from another question that asked the centers to "rate the quality of assessment and preparation for treatment services offered by the following groups". The following Table 21shows the results:

TABLE 21

Rate the quality of assessment and preparation for treatment services offered by the following groups

Groups	1	2	3	4	5	Mean Score
Child and Family Services Workers	5%	10%	60%	20%	5%	3.1

Social Workers	–	11%	68%	21%	–	3.1
Mental Health Workers	–	35%	45%	15%	5%	2.9
Community NNADAP Workers	15%	15%	50%	5%	15%	2.9
Self Referrals	10%	30%	40%	20%	–	2.7
Physicians	5%	40%	40%	10%	5%	2.7
Correctional Institutions	11%	37%	32%	21%	–	2.6
Referral by family	15%	35%	40%	10%	–	2.5
Court Referrals	15%	45%	30%	5%	5%	2.4

**1=Poor and 5=Excellent*

Mean scores for all referral groups were rated from average to just a little better than poor. During our field visits to treatment centers the lack of adequate preparation and inappropriate referrals of clients was cited as one of their most frequent frustrations. Reasons most often cited by the treatment centers for the poor referrals were high turnover and lack of training of community NNADAP and other social/health workers.

Pre-treatment programs should be developed or models for both the community level and treatment centers. Pre-treatment can be defined as an assessment, orientation, and readiness phase to treatment of clients. Length of pre-treatment programs should vary depending on the treatment program itself and range in length from one week to three weeks. Consideration should be given to use existing pre-treatment developed by Society of Aboriginal Addictions Recovery (SOAAR) for Corrections Services Canada.

3.4.11 Treatment Activity Reporting System (TARS)

Finding:

- ***TARS system does not have the confidence of a majority of its users in the treatment center system***

Feedback from the treatment centers about TARS usefulness was rated "somewhat useful" by 45%. Twenty-five percent of the centers rated TARS as "not at all useful". Only 10% of the centers felt that TARS was "very useful" followed by 20% saying it was "useful". These findings would indicate serious problems with the TARS system. During our field visit interviews we asked treatment staff for their feedback about their rating of TARS. Four questions were asked: (a) *"Do you do analysis of TARS data and how"? (b) What is your opinion of TARS? (c) What is your impression of how TARS information is used? and (d)What suggestions do you have for improving*

TARS?. The following is a sample of their responses to these questions:

- TARS is used to reduce funds - i.e. Must reach 80% bed utilization on TARS or our funding will be reduced;
- Would like to develop our own evaluation tool separate from TARS to be more relevant to the center;
- Need information from TARS about what drugs are causing the most problems;
- TARS is not specific enough to be of much value;
- Helpful;
- Would rather develop our own data system that is relevant to the uniqueness of our program;
- Tired of the numbers game that TARS is used for.

Responses to the last question for improving TARS were:

- Needs to be relevant
- Many of the questions TARS asks don't make sense;
- TARS lacks flexibility and doesn't allow changes;
- Scrap TARS and provide funding to the programs to develop their own data systems.

Based on the results obtained from the mail surveys and the field visits there is no question that the TARS system does not have the confidence of a majority of its users in the treatment center system. It is viewed by a significant number of users with suspicion; many expressed frustration with the inflexibility of TARS; and a significant number of centers would prefer to develop their own data system. It is also apparent that concerns about TARS' effectiveness have been expressed for many years.

In summary Treatment Activity Reporting System (TARS) needs to be revisited with input from all the treatment centers that use this system. Efficiency and cost analysis of either developing a new national system or allowing treatment centers to develop their own data system needs to be explored in order to determine the most effective response to drug and alcohol issues. TARS needs to have additional capabilities such as client monitoring systems for program information and accountability; tracking client outcome, and measuring quality assurance programs for the treatment centers. This has been further supported earlier in this report in the funding category where the treatment centers identified efficiency and effectiveness as more important than per diem rates.

3.4.12 General Treatment

Finding:

- ***There is no process for ensuring that treatment beds are accessible to those communities seeking to make referrals.***
- ***At times there are official or "unofficial" policies within Health Canada on activities such as transportation or payment for medical assessments which have a negative impact on clients ability to access treatment services***
- ***Aftercare and Follow-up programs for clients within NNADAP treatment programs are optional in the vast majority of programs.***

Even when examining models of good practice such as Round Lake and Rama described previously, a mandatory structure would assure that there was a basic system of contact for clients following treatment. From field visit interviews, it is evident that community members, persons in the communities who have experienced treatment, and community based NNADAP workers, all cite the highly variable, and thus inconsistent nature of aftercare/follow-up programs. Two other communities who have comprehensive pre-treatment and follow-up are Ahtahkakoop and Akwesasne. These community models are examples of pre and post treatment and planning which could be further examined. The pre-treatment program developed by Correctional Services Canada is also worthy of study.

For example, dependent on the community, there may be organized follow-up or available support groups including AA, and discussion groups and healing circles of various types and target groups. However, there are significant numbers of communities, which do not have these types of services. In addition, according to the client focus groups, most clients during discharge planning make a choice as to whether they participate in the aftercare program.

The optional nature of aftercare is a problem, since many clients feel strong and capable while at the treatment center and choose not to participate. A mandatory system of follow-up would provide at least a minimum structure of contacts, which potentially would be a means of tracking outcome and effectiveness of the program. A mandatory aftercare/follow-up process would also resolve the current discrepancies within the system, where treatment centers and community workers refer to regular aftercare activities while the clients are not always aware of the intent or the existence of these activities. To be effective, a mandatory process should have clear responsibilities for both the treatment centers and community based staff and a system for ensuring compliance.

A barrier to treatment cited during community visits was the amount of time required to determine availability of treatment services. This affects workers' ability to match clients to treatment programs in a time frame conducive to continued recovery. At times, there were occasions where there were 9-month long waiting lists, particularly with respect to specialized treatment programs such as Tommy Beardy Memorial Center in Muskrat Dam, Ontario. This situation is difficult to understand since there are centers who report through the Treatment Activity Reporting System (TARS) that they have a high level of vacancies. This is especially of concern, since there are reports that some regions wish to close centers or re-devote these centers to more general purposes.

It was found that there were occasions where Health Canada policies of national or regional origin were barriers to individuals seeking treatment. For example, the regional policy on transportation outside of the province may be literally interpreted by either the region or the respective community worker as not permitting necessary travel. This situation presents a problem when considering that treatment programs were established to be available to any First Nation, the lack of a variety of treatment modalities within each province, and circumstances where the nearest treatment program for a particular community may be across the provincial boundary.

A further complication to potential clients of NNADAP treatment programs is that many persons experienced problems in obtaining detoxification services for persons prior to entering treatment programs. This is a serious concern with prescription drug abusers who require detoxification. Some drug users require a minimum of one-month detox period. Improper detoxification contributes to early self-termination from treatment. In the Atlantic Provinces, it has been noted that as a result of provincial health reform, there has been a reduction of hospital beds and/or closure of many local hospitals. This has affected the availability of detoxification services since many of these locations targeted a limited number of beds for these services. Since most provinces have implemented similar reforms, there should be active advocacy on the part of Health Canada and First Nations and Inuit organizations to ensure that there are protocols developed to facilitate services to NNADAP clients.

There may need to be alternative strategies developed to deal with detoxification needs, if availability of services remains an issue after such discussions. In visiting communities, it became apparent that, in the fly-in communities, the NNADAP workers were expected to supervise persons who were detoxifying from alcohol and solvents. This situation arises since, at times, there are not services available to look after clients at the nearest referral city, or the longer-term treatment programs are not available for periods ranging from a few days to weeks and months.

3.5 Training

Finding:

- ***There is an inconsistent level of training, particularly for remote or northern communities. Basic training is not related to positions and there isn't a systematic orientation available for new workers to assist them in carrying out functions before basic training is scheduled.***
- ***Advanced Counselor Training does not occur in an organized fashion in every region. Also when workers do complete advanced training, there is not a process to adjust salaries as an incentive for advancement.***
- ***Advanced Specialized Training in either addictions or addictions- related topics is not systematically available. That community prevention and health promotion needs to be made available or developed to better serve the 60% of the First Nations and Inuit population who are 30 years or younger.***
- ***Health Canada in collaboration with First Nations and Inuit representatives should negotiate accreditation with a group such as the Ontario Interventionist Association to utilize the title of Certified Alcoholism Counselor or to develop a similar accreditation process.***
- ***General Training, such as computer programs, the Internet, financial systems and other similar areas which would benefit NNADAP workers are not systematically available***

There will be additional comments made about training requirements in the section on the information systems requirements to support both community-based and treatment programs. However, there has to be rethinking of the NNADAP training (or capacity building) process, based on the sweeping changes in the training environment which have occurred since the training programs were initially implemented. For example, Canada Employment and

Immigration Commission, (CEIC now Human Resource Development) programs have undergone several fundamental shifts, which now have serious impacts on the current training situation.

The Pathways program has evolved from Regional Area Management Boards, which tended to support general capacity building efforts such as NNADAP and CHR training, to Local Area Management Boards. These local area boards have many competing local interests that may not place a priority on NNADAP training. This situation is exacerbated by training demands of other workers such as the Community Health Representatives, Mental Health Workers, and Child and Family Services Workers. Training has been done with no additional resources as may be seen from the National NNADAP Financial Study, included as part of this review.

Interviews conducted during the community visits indicated that there were NNADAP workers who did not have access to training, particularly in northern and remote communities. The reasons cited were a lack of resources, workers who did not meet prerequisites for admission, and the existence of a long waiting list for training. One alternative strategy is to target training seats or resources to new or vacant positions. Such a strategy would be similar to that described in the Treasury Board Submission establishing NNADAP which had targeted resources to positions.

The original design of NNADAP envisioned that there would be advanced and basic counseling level positions. The most effective way to implement different levels of positions would be to correlate increased salaries to the attainment of certification. One of the most common models for this is the Ontario Interventionist Association, which has the Canadian rights to accredit individuals with the title, Certified Alcoholism Counselor, CAC.

As may be seen by the following tabulation on the degree of importance placed upon various responses of desired training, the scenario, which emerges, is that there should be a process to involve First Nations and Inuit organizations in the design and delivery of training. The responses indicate a desire to have training recognized by a professional body, followed by provincial addiction agencies through diploma programs and bachelor programs.

Existing training curricula would need to be reviewed to assure that graduates would meet the knowledge areas of the certification program that emerges. However, the certified alcoholism counselor program is familiar to most training agencies. To a certain degree, there are existing accreditation panels in each region. It should be possible to negotiate the certified alcohol counselor concept targeted at First Nations and Inuit workers. Health Canada and First Nations and Inuit organizations should consider attaining accreditation with such group to utilize certified alcoholism counselor title or develop a similar accreditation process. The program could also consider granting parallel privileges to individuals with certain educational qualifications such as Bachelor of Social Work, Master of Social Work, psychology, or other fields, which would be considered equivalent.

The following is a summary chart showing by descending order of importance, the factors considered important by First Nations leaders, NNADAP community workers and management of NNADAP treatment centers. There is remarkable consistency in the reported preferences. There is a slight variation indicated by treatment center respondents showing a lower rating for recognition by provincial addictions agency. In part, this may be explained by the differing views for each type of worker with respect to recognition by the respective provincial addiction agencies. For example, in Manitoba, the province does not recognize assessments performed by Health Canada trained NNADAP community based workers for clients cited for driving under the influence. This leads to frustration on the part of workers, not to mention duplication and inconvenience for clients.

TABLE 22

What Elements are important when considering training for NNADAP Workers?

Important Elements	Leaders	NNADAP Community Workers	Treatment Centers
Aboriginal involvement in curriculum development	4.5	4.3	4.5
Native Trainers/Instructors	4.4	4.3	4.2
Recognition by First Nations and Inuit	4.4	4.4	3.8
Access to specialized Training	4.4	4.4	4.1
Recognition by Professional Body	3.9	4.1	3.8
Recognition by Provincial Addictions Agency	4.2	4.1	3.4
Diploma program, college	3.9	4.0	3.8
Bachelor's degree, University	3.4	3.3	3.2

*1 = Not Important 5 = Extremely Important

3.5.1 Developing A Resource Pool of Trained Workers

In the mid-1980's, Quebec region had developed a strategy to train individuals before employment in community addictions and treatment programs. The Treatment Center at Kitigan Zibi reserve in Quebec carried out the most recent example of this approach to training. A benefit of this approach is that it enables use of retraining and skills development funds through Human Resource Development and from social assistance programs. Training of a cadre of potential workers prior to actual employment would seem to make a great deal of sense since both NNADAP workers (51%) and treatment centers (63%) report problems in recruiting qualified staff.

3.5.2 Treatment Centers as training centres

The previous discussion of utilizing treatment centers as training hubs for catchment areas remains a practical approach to dealing with orientation and advance training. This is evident from the current pattern of preference and utilization of training sources rated by treatment center and community workers as summarized below:

TABLE 23

Preference versus utilization - various types of training

Methods Of Training	Treatment Centers		Community Workers	
	*Prefer	*Use	*Prefer	*Use
Workshops	4.2	3.9	4.4	4.2
Speakers (consultants)	3.6	3.8	4.2	3.3
Diploma Program	3.6	4.1	4.2	3.3
Special Program at College or University	3.5	N/A	4.0	N/A
Distance Education	3.3	N/A	3.8	N/A

*(Prefer 1= Not important 5 = Extremely important)
*(Use 1 = Not used at all 5 = Used extremely frequently)

Reported rates for participation in advanced training are high, with 64% of community based NNADAP workers and 68% of treatment center respondents indicating participation in advanced training.

The Review Team also found that 75% of centers conduct on the job training. We also asked the staff in the treatment centers whether they received advanced or specialized training, to which 68% responded yes. Specialized training was most frequently obtained through community college courses followed by in-service training. The use of workshops was ranked third in frequency for receiving specialized training.

3.5.3 General NNADAP Training

Diploma programs, recognition by a professional body, and recognition by First Nations/Inuit ranked high in importance for elements of training. These three training elements were expressed with the most frustration by not just treatment center staff, but also by the staff we interviewed in our community site visits and at the Regional meetings. The source of their frustrations appears to lie in the fact that many of the staff working in the alcohol and drug field have taken much training that has been rated as good to excellent. However, many find that all their training has no credit value and/or is not recognized by other educational institutes, accreditation bodies, and even by their own peer groups. For example many felt they could not apply for other jobs in the helping field because their training is not equivalent in value for meeting the requirements. This is further highlighted when compared to their counterparts working in the alcohol and drug field but not attached to the NNADAP system such as provincial alcohol and drug workers.

Both the treatment center counselors and the community alcohol and drug workers identified specialized training in several areas. Though they were not ranked in this Review, feedback from the field visits and the regional focus group meetings consistently identified the following areas; (a) advanced counseling; (b) residential school affects; (c) sexual abuse/violence; and (d) depression. The above issues of residential school affects and sexual abuse/violence and depression are also consistent with the major mental health problem areas that clients present in both their communities and reasons for treatment.

First Nation educational institutions that have achieved provincial post-secondary need to be supported and promoted by not just First Nation communities and their political bodies, but also by the Provinces and the Federal Government. Financial and political support from both the Federal and Provincial levels are needed to assist First Nation educational agencies to carry out the research and curriculum development needed to reach first class status and recognition that are afforded to colleges, universities, and provincial and national accreditation bodies.

3.5.4 Related Training Needs

In addition to areas relating to training on addictions or related topics, it is evident that there should be an additional focus on capacity building by Health Canada in at least two areas.

This study has identified the types of equipment available at the community level. 72% of workers reported availability of computers and 47% reported availability of the Internet. It should also be noted that every First Nation school in Canada is being equipped with computers and Internet access that should serve as a tool for communication, information and training. This is significant when considering that only 14% of persons report competency with those tools that are already available such as internet.

A second area of need is multi-disciplinary training. 79% of Social Workers and 70% of Health Workers expressed interest in areas of joint training that would promote effective approaches to addressing community needs. Suggestions from health and social services workers on the open-ended questions regarding areas of joint training covered a range of potential topics. The most common suggestions were case management including areas of addictions such as aftercare processes, fetal alcohol syndrome, general information on alcohol and drug abuse, referrals and assessment processes. In addition, there was considerable interest in topics such as suicide prevention and intervention, family violence, child sexual abuse, crisis intervention and other topics of a similar level of impact upon the community level.

3.6 Systems Approach for NNADAP

Finding

- ***The NNADAP program does not function with an overall philosophy that includes different individuals, programs, and treatment services as part of an overall system of care for addictions.***

In conducting the field site visits, in general, there was not an overall sense of organization of the different elements within the NNADAP program in order to assure the individual and collective effectiveness of those programs and services funded by Health Canada to deal with addictions.

To be fair about this assessment, however, it is important to be cognizant of recent evolution within Health Canada and the Department's relationship with First Nations. This evolution affects both the theoretical and practical lines of authority for health programs. In recent years, Health Canada, First Nations and Inuit Health Programs Directorate has adopted a vision "First Nations and Inuit people will have autonomy and control of their health programs and resources within a time frame to be determined in consultation with First Nations and Inuit".

Similar to the Department of Indian Affairs and Northern Development, the current situation is a result of deliberate policy direction but also as a result of rulings from the Canadian Human Rights Tribunal. This has put pressure on the federal government to avoid possible interpretations that it is directing or defining the work of the programs or of the individual workers within them. In circumstances where communities or treatment programs are operating under the Transfer Policy of Health Canada, the communities may adjust and theoretically eliminate programs as long such actions are within the parameters of the community health plan and as long as the respective organization carries out mandatory program elements such as communicable disease reporting and immunization,

In practice, at the risk of generalizing, even communities not yet under the transfer policy are treated with a similar hands-off approach. Therefore individual communities and treatment centers tend to be left on their own particularly with respect to individual programs such as NNADAP. It is important to realize that the Community Health Representative program, Brighter Futures and Building Healthy Communities are handled in a similar fashion.

Certainly, self-determination and self-government are the goals of First Nations and Inuit peoples and such directions are consistent with the recommendations made by the Royal Commission on Aboriginal peoples. However, the interactive and interdependent nature of addictions programs in the original design of NNADAP and the regional nature of many of its services, demand that there be a systems approach to enhance the probability of success in dealing with addictions. Program elements such as training, technical advice and clinical supervision, and reporting and data gathering are not generally available or practical at the community level.

In examining the rationale for a systems approach, it is necessary to examine the essential elements of the system in order to determine the appropriate vantage point from which it is possible to contribute to the effective functioning of the systems. In this discussion it is important that the community-based perspective be kept in mind. The design of the Review from the outset was to examine the needs of the program from the grassroots up. Therefore, the intent of the system discussion returns back to the question "What will help community programs be more effective in dealing with the addictions needs of its people?"

A costing should be developed from the perspective of all types of services and programs that should be made available in each community. Part of the package should identify the context in which advanced counselors would be recognized and those circumstances whereby part-time workers are necessary. This will facilitate a process by which First Nation leadership can more effectively allocate funds available for the programs and to determine potential shortfalls. Health Canada and First Nations should consider these estimates as a benchmark for all communities and determine opportunities to meet demand. Such a process should be linked to the implementation of an outcome based reporting system

Also it is important to state that discussion of a systems approach does not automatically imply that there are no elements of the system in place, but rather that the system is not in place in all regions or at the national level in a consistent and strategic fashion. It should be stated that the First Nations leadership is a key player with Health Canada for required follow up actions and "leadership". Where there are recommendations for immediate action assigned to Health Canada, such areas of responsibility should not necessarily remain with Health Canada on a long-term basis.

Finding:

- ***There is no systematic leadership or support provided to communities and treatment centers. The number and value of interaction between regional operations and communities and treatment centers is highly variable.***

- ***The quality of interaction between treatment centers and community programs is inconsistent and has a negative impact on the success with clients.***

- ***There are no standards or process for accrediting workers***

- ***There are no program standards for either community-***

- For example, in the course of field visits, it was observed that new workers, particularly in the more isolated and remote locations, were not oriented to such procedures as referral, assessment or other basic information. This would be critical for a new addiction worker who as yet would not have had access to training. To their credit, workers were able to deduce basic procedures by reading files. However, various regional policies on transportation, escorts, and procedures and basic information about treatment programs available provincially and nationally were not available. This situation, in many cases has been detrimental to providing effective services to people within the community.

The opposite circumstance also exists, and there were excellent examples of good practice by individual workers or programs. For example in Rama First Nation, the counselors visit the treatment programs before referring clients, make referrals, follow up on the clients during the treatment program and participate in discharge plans made for clients. In addition to Alcoholic Anonymous (AA), there are a number of healing circles for various target groups such as women, men, victims of violence, and others which have been developed and are part of the follow up.
One of the observations that the study team has made as a result of the various forms of input and data gathered through the review is that there is no evidence that there is 'leadership" in addictions provided in a systematic fashion. In making this observation however, what is obvious is the opportunity to respond to an interest in various groups playing a stronger role in providing useful materials and information

on addictions. It is the view of the Review Team that Health Canada is reluctant to play the central leadership role. However, as can be seen from the following table, it is felt by NNADAP workers that MSB headquarters rated highly as a source of useful materials and information and further that there would be benefit in having Health Canada play a stronger role in providing materials and information.

TABLE 24

Comparison of questions on support groups and resources

Groups/Sources	Does your program receive useful information and material from the following sources?		Which groups do you feel would be of benefit to you if they played a stronger role?	
	NNADAP Workers	Treatment Centers	NNADAP Workers	Treatment Centers
Aboriginal Health Institute	*N/A	*N/A	3.9	3.8
New Aboriginal Addictions Agencies	*N/A	*N/A	4.1	3.9
Workshops and	3.7	3.2	4.3	3.8
MSB Headquarters	3.0	2.8	3.6	3.5
Nechi Institute	3.0	2.4	3.9	3.9
Regional Consultants	2.9	3.0	3.9	3.9
Zone NNADAP	2.8	2.3	3.9	3.8
Native Training Institutes	2.8	2.2	4.0	3.5
Other MSB Regional Staff	2.7	2.4	3.4	3.7
S.O.A.R	2.7	2.3	3.9	3.4
Provincial Addictions	2.7	1.9	3.9	3.6
Tribal Council NNADAP Coordinators	2.6	1.9	3.9	3.6
Community colleges and universities	2.6	2.7	3.8	3.5
Consultants	2.5	2.5	3.4	3.3
Assembly of First Nations	2.4	1.8	3.6	3.0
PTO Health Staff	2.1	1.7	3.2	2.8

* N/A – Not available (these organizations do no exist yet)

From Table 24, it is evident that there would be considerable support for a new Aboriginal Addictions Agency or an Aboriginal Health Institute as a prospective source for information and materials in support of community projects and treatment centers.

It is worth noting, in general, that community workers expressed relatively low levels of satisfaction regarding the materials and information received from most sources. Similarly, in general, treatment center respondents rated sources consistently lower than community based respondents.

There was some discussion during the field visits and during the group debriefing by the review team of the potential role that could be played by selected treatment centers (and potentially all) in training, as a central coordination point for aftercare programming and as a potential site for networking and providing information to community workers within the geographic area served by the center. This approach would ensure that community workers are familiar with the treatment programs and that training is available on referral, assessment, and treatment follow-up. Treatment centers present in focus groups were cautiously interested in such a possibility. However, there was concern that the centers would have to have their funding process and criteria amended to make this feasible.

Round Lake Treatment Center is an example of a treatment center, which would be a source of expertise on a more national scale, particularly with its innovative work in aftercare, and outcome based treatment information systems. This center and other examples of exemplary program design and operation should serve as role models and training sites for other programs with funding to support such activities.

3.7 Integration Opportunities

3.7.1 Integration of addiction efforts within Health Canada

Finding:

- ***There is a lack of a common strategy within Health Canada for dealing with various addictions within First Nations and Inuit communities, which limits the effectiveness of individual programs at the community level.***

One area of concern which was not necessarily addressed as a distinct component within the Review of the NNADAP program is that there are several distinctive areas of funding of addictions areas within Health Canada including solvent abuse, tobacco, and core funding for such items as the National Native

Role Model program at Kahnawake. Particularly when one considers the potential emergence of new areas of addictions such as gambling, it makes sense to build a basic infrastructure for programs, which can provide for the systems to support research, communications, information gathering, coordination, and training, and evaluation.

In addition, there are some aspects of the solvent abuse model, particularly with aftercare, which may have been of relevance to the development of effective models for alcohol and drug abuse. Certainly, there may be as well, some practical examples of funding models and payment processes. This is not intended to be a criticism of the focus of the study, but rather to point out that there are important opportunities to combine systems related efforts between the various addictions "silos".

For example, participation in the development or adaptation of a system to assist in determining bed availability would be of obvious benefit to community based workers seeking to make referrals to solvent abuse programs. This is important to consider since through the Building Healthy Communities program, there is funding provided to communities in the area of solvent abuse. In some communities, solvent abuse workers have been hired. In one of the communities visited, the NNADAP workers had no choice but to handle detoxification needs of several youths waiting for an opening at a solvent abuse treatment center since the solvent abuse worker did not have training or experience in means of handling the complex problems associated with chronic solvent abuse. The NNADAP workers did not necessarily have training in this area either; however, they handled the issue with an admirable sense of duty and commitment.

3.7.2 Integration of Community Based Healing Planning

Finding:

- ***There are not clear concepts about the desirability of integrating various community-based healing efforts, and the principles under which integration should occur.***

There is no question that the various programs available need to be integrated within an overall strategy directed at the community level. As discussed in the section on coordination with other services, there is a need to better coordinate services and to communicate regarding the services provided at the community level. In some communities this is very well done, and these communities can serve as models.

On first examination, decision-makers or programmers are tempted to simply state that all funding and approaches should simply be blended into one overall pot of funds, which could be focused on "Healing". However, there are some issues, which should be kept in mind when focusing on real life attempts to simply consolidate funds.

3.7.3 Achieving a balance between mental health and addictions workers

There is real debate in health care circles, not only in First Nations communities, whether alcohol, drugs, and other substance abuse is a primary problem by itself, or whether substance abuse is merely a manifestation of other more deeply rooted problems. Put simply, there are real debates over whether substance abuse is a cause or an effect. Part of the argument for those who see substance abuse as a cause is that various addictions are characterized as diseases as defined by WHO, the American Medical Association, etc. This debate is of interest since it affects the way programs are organized. Some mental health workers, among others, tend to put alcohol and drug abuse down the scale of importance. On the other hand, those who feel alcohol is a disease tend to focus solely on the addiction and relate all of a community's social and health ills to this.

In the final analysis, this issue should not be allowed to determine which program is higher on the ladder of supervision or decision-making. Substance abuse causes tremendous problems in First Nation communities and seeking to determine which issue came first is less important than the need for real integrated team approaches to dealing with community problems. In some ways it should be argued that substance abuse is both cause and effect. If a person has problems with addictions they will probably experience other manifestations of serious mental health problems such as other forms of abuse or inability to deal with life's problems and challenges. In addition, there is a likelihood of physical problems such as diabetes, heart disease, and ailments reflective of chronic abuse such as cirrhosis.

In addition, having a pure addiction focus is not realistic since it is commonly understood that persons utilizing residential treatment programs also have issues in family violence, unresolved grief, family problem solving skills or sexual abuse. As an added point, it was very clear from the survey results that there were similar expectations for the NNADAP community workers to have skills and abilities in family violence and sexual abuse.

It is difficult and perhaps impossible to reach or to maintain a perfect balance in the relationship between mental health programs and addictions programs. It is more important to recognize the need for such balance and to strive for the recognition of the roles that both programs need to play in developing healthy individuals, families, communities and Nations.

3.7.4 Good team requires a good two-way flow of information

A partial manifestation of this conflict in philosophy described above is the territoriality with respect to information held by various workers in the helping areas. For example, an alcohol worker might be expected to provide referrals to mental health professionals or to community based mental health workers. Yet, there seem to be a lack of communication for those same mental health workers regarding the outcome of the referral, or in making referrals back in the other direction. Such practice causes fundamental problems in the development of real team approaches to dealing with community members. Physicians making referrals are often reluctant to work in a team process with issues such as prescription drug misuse.

In addition, in some communities and in particular in small communities, there may be several different employers for the various members of the team who will be working on issues or clients who are in common with the NNADAP worker. For example, in some communities, the First Nation or Inuit organization is the employer of the NNADAP worker and the CHR. The Community Health Nurse is an employee of Health Canada. The psychologist is an independent contractor paid through Non-Insured Health Benefits under a fee for service arrangement. The mental health worker is employed by the band or by a separate organization (for example Nodin in Sioux Lookout Zone). The Child and Family services worker is employed through a tribal council organization (such as the Ojibway Tribal Family Services) funded through various mechanisms and governed by provincial legislation.

In such a scenario, the workers could legitimately claim that there are confidentiality issues, which would prevent them from sharing information about clients or about traumatic events in the community such as suicides. Such situations, however, represent serious and unnecessary barriers to effective teamwork. However, there need to be methodologies and procedures for sharing information that respect legislation, yet enable sharing of information in a way that will facilitate teamwork, improve coordination, and assure proper services to persons within the respective community. It is likely that there would have to be protocols developed in each provincial jurisdiction.

As addressed in the previous section on coordination, the need for case management models and training in such models should be a real focus for both Health Canada and other federal departments as well as First Nations and their organizations.

3.7.5 Suggested Approach for Integration of Community-Based Programs

Of necessity there have to be at least two approaches to deal with needs for integration of services based upon the differing realities facing community based programs versus treatment programs.

3.7.5.1 Integrated Health Services Delivery Systems – Community Level

The most promising concepts emerging from federal and provincial health reform efforts is the development of integrated health services delivery at the community level. A review of the evolution of health care concepts emerging from similar experiences in other nations such as New Zealand, the Netherlands, and the United States all point to the need to integrate health program efforts with a focus for such efforts within the primary health care concept.

The definition of primary health care according to the World Health Organization (WHO) is as follows:

> *Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community, through their participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.*

Primary Health Care by its definition also includes a full range of services and responses including those that are promotive, preventive, curative, supportive, and rehabilitative and utilize approaches to health that relate to other sectors (e.g. broader determinants of health).

As noted above, the current structures at First Nations reveal the large number of organizations that co-exist within a local health and social services delivery system. The Health Canada model for Health Transfer takes the first step by unifying federally provided health services under a management structure determined by the respective First Nation. However, even under Health Canada there are several elements which remain outside of the Transfer structure, most notably the resources and services provided under Non-Insured Health Benefits.

As may be recalled under the discussion on funding, the federal government will likely move towards Federal Transfer payments. Therefore, the community will be pressured to use an integrated funding instrument, which potentially could combine funding from all federal sources into one agreement. Given the nature of social services provided through DIAND, there is merit as well to consider combining health and social efforts at the community level. However, such funding arrangements although possible today, will likely take time to implement on a broad scale among the various federal departments.

In addition to federal services, many communities also have services provided by the respective province either as direct service or through contractual arrangements. This provides additional sets of players in health and related social services. First Nation individuals generally qualify for insured services which provide for physician services, secondary and tertiary level of hospital and specialist services and varying types and levels of supportive services such as physiotherapy, optometry, and other services of a similar nature.

It will not be practical for First Nation communities to directly provide all health and social services themselves, particularly in secondary and tertiary levels of services. Nevertheless, it is important that communities eliminate unnecessary program silos. To do so will at minimum require the development of protocols for release of information and potentially, the unification of community based services under local First Nation management.

The point of this discussion is that there is an obvious need to promote integration efforts at the level of First Nation and Inuit communities. One argument for pursuing such a direction would be that it is important to take the concept of health reform to the community level. Integration efforts by communities will need government support and encouragement. Part of what will be required will be assistance in overcoming administrative barriers to integration; Nunee Health and Ahtahkakoop provide successful models for others to examine. This approach would be consistent with the recommendations on resource centers or centers of excellence.

However, in providing support for integration efforts, it is important to realize the difference between integration approaches and approaches which simply eliminate programs to create one big block of dollars. In an integrated approach such as the one described for the Rama First Nation, each program area has its distinct area of responsibility in providing for the needs of the community. There is a common intake and record keeping process, which does the necessary assessment and referral to the appropriate worker, which does not always correspond to the program boundaries. However, the release of information forms signed by the client during intake ensures that there is effective and timely case conferencing to assure that the clients needs are being met.

In general, block-funding approaches are a desirable outcome. However, adopting a model of block funding without program standards would result in elimination of program boundaries. This may result in a loss of program focus in an area, which obviously remains extremely important for First Nation and Inuit communities. Further discussion would reveal that a pure block funding approach would have the disadvantages associated with the lack of a systems approach to support addictions program needs as discussed in other sections of this report. In effect, this action would to a large degree leave communities on their own since there has not been a strategy to provide for training or other activities in support of community based efforts. The other disadvantage of pure block funding would be the potential loss of profile for special funding initiatives such as NNADAP or AIDS or other areas of obvious focus for programs. Once permitted, there could be an irretrievable loss of identity of such funds.

Therefore, in addition to implementing a rational strategy for providing support to community efforts, the development of program standards, and development of effective information systems are critical at this time. These activities must be undertaken to assure that the critical area of addictions is dealt with in a fashion that will lead to success regardless of the funding instruments used. If in place, these structures will support efforts to integrate programs in a manner that supports planning, accountability, evaluation and research.

3.7.5.2 Integration of Treatment Centers into healing approach

At least one regional jurisdiction within Health Canada is considering re-deploying treatment centers as Healing Centers. In considering this type of action, there are several considerations for treatment programs, which to a degree parallel the considerations offered in the section on integration of community based programs. Some considerations that should be reviewed in taking this decision are as follows:

3.7.5.2.1 The tertiary nature of Treatment

Treatment centers are generally not community based. The implication for this is that before treatment centers are converted to another purpose, there should be discussion with communities generally served by the treatment center as to how the addictions treatment needs of clients would be dealt with if the center were to be used for another purpose. In this discussion, it is not enough to state that clients would be sent to other centers, if such action were not practical from a logistical point of view or from the perspective of availability of beds. Since most workers refer to the lack of availability of beds, there are legitimate concerns that taking such actions would make this circumstance even worse.

Furthermore, treatment beds are considered to be national beds. Certain regions have made presentations as to why they should be considered for extra beds. If this circumstance no longer exists, consideration should be given to re-pooling operational dollars to be allocated to deal with the considerable level of unmet needs. If the facility is then available, it would make sense to use it for other purposes using funds from other sources such as Brighter Future's, Building Healthy Communities, or the new Healing fund.

There are lack of treatment programs for special target groups such as families, youth and couples. In addition, the review has indicated that there is a lack of specialized programs to focus on the above noted groups. At this point, before re-devoting these programs to other purposes, it would seem to be important to make a serious attempt to provide services for these under-served groups. As mentioned previously, community workers report waiting lists for as long as 9 months for certain types of treatment. The study has also revealed that there will likely be a requirement to deal with new forms of addiction such as prescription drug abuse and gambling.

3.7.5.2.2 Impact of Changes to Non-Insured Health Benefits

There has been a pattern of elimination of use of funds from NIHB for referral to non-NNADAP treatment centers, increasing pressures to reduce transportation costs, and transfer of distance transportation to local control which will have an impact on treatment center functions. Therefore, prior to deciding on treatment center operations, there should be an examination of the long-term impacts of these trends and the potential effects upon First Nations clients.

3.7.5.2.3 Suggested Approach for Integration of Treatment Centers

While the above noted consideration merit a cautious approach to the issue of use of NNADAP treatment centers as healing centers, there could be ways of approaching this issue which will ensure that there is development of a healing strategy that will benefit First Nations.

- Both the mail survey and field visits reveal that treatment centers tend not to utilize outside professionals or therapists as a structured part of their programs. This situation is not totally related to practice but also is due to budgetaryconstraints and to preliminary program design, which promoted non-medical approaches.

  Making additional professional therapeutic program staff available for management would promote the ability of the center to deal with the issuesfacing clients in these alcohol and drug abuse treatment programs.

- Developing a strategy for Healing involving addictions programs
  There may be merit to having regional and/or national strategies developed which have an overall focus on dealing with healing. If multi-disciplinary working groups are used to develop these strategies, there could be a cooperative; team oriented focus in dealing with the healing needs of First Nation and Inuit communities. Similar to the discussion on the need for balance for mental health and addictions within community organizations, there is a similar balance needed regarding healing approaches. A similar relationship exists between a person's use of substances and ability to proceed on a healing journey. The two situations need to be complementary, since a person will not be able to heal while abusing substances.

- Perhaps one strategy which could involve treatment centers, would be to feature "advanced" treatment which would focus on healing. Community participants in treatment focus groups tended to favor the possibility that there could be a second stage of the treatment plan to assist in personal healing and to focus on acquisition of traditional knowledge and ceremony for continued personal development. There are some people who attend treatment again after being sober for 2 to 3 years due to the need to deal with unresolved issues. This second stage treatment program design could accommodate this client group.

- Examining healing approaches adopted in other jurisdictions
  There are healing Lodges, which have been in operation in other jurisdictions, although in general, such initiatives tend to be of relatively recent origin. Examples of this include the Selkirk Healing Lodge in Manitoba and numerous healing lodges, which have been funded in the province of Ontario under the Aboriginal Healing and Wellness Strategy. It would be useful to examine these programs to determine the potential areas of success or problems faced by these programs in their period of existence.

  Part of the difficulty with such approaches is the wide range of potential problems that persons wish to deal with at a healing lodge. Sexual abuse and family violence issues, identity problems, relationship issues, grieving issues, and other concerns are difficult to assess, and also would make it difficult to offer a standard program. The need to conduct an assessment as to when the client may be in need of an intensive long-term therapeutic process would have to be monitored. Involvement of mental health workers in assessing clients who have dual problems of a psychiatric nature in addiction to substance abuse would need to be safeguarded.

- Conducting a pilot
  Health Canada and First Nations should consider development of regional and national healing strategies, which would involve working groups such

as community NNADAP workers and treatment centers among others. A study of existing healing lodges should be carried out to investigate the potential benefits and liabilities of this approach. Finally, as part of an overall strategy, there is merit in having a pilot project, which would examine in detail, and implications of changing focus for treatment centers

This pilot project could involve a treatment center's conversion to a general healing center. However, in advance of this activity, there should be a proposal process, which would require some preparation and research into desired approaches and suitability for an innovative project of this nature. Once a center is selected, there should be funding support to develop the necessary program, training and evaluation criteria so that the pilot phase will be useful to others.

3.8 Research and Development

In the original plan for NNADAP, the research and development component of the program was intended to provide the means for determining levels of the various addictions within First Nations and Inuit communities, assisting in the development of effective prevention and intervention strategies, and in implementing an information system that would provide for an ongoing evaluation and research capacity. Part of the presumed rationale for this would have arisen while researching necessary data and information upon which to develop the Cabinet Document and the subsequent Treasury Board submission for NNADAP. It is interesting to see the degree to which assumptions were made about the level of care and the degree to which extrapolations were used to determine need and level of services required within the proposed programs.

It is interesting to note, as well, that in conducting the necessary literature search in Aboriginal addictions prior to developing the review framework, the former NNADAP research and development program has left a visible legacy of studies that can be used to study aboriginal addictions.

While there may have been operational considerations to decentralizing funds formerly allocated to Research and Development to regional operations, in retrospect, it would seem to have been more strategic to refocus the Research and Design component from essentially a proposal driven process to more of a directed research program which could develop and carry out some of the basic research needs faced by addictions programs.

There was an important opportunity within the First Nations longitudinal health study which could have resulted in community based collection of utilization of various substances. In the current version of the study, there are no systematic incidence related questions. This is a curious circumstance given the detailed focus of the study on other more intrusive areas such as sexual abuse of children.

The conduct of pertinent surveys could assist in anticipating areas emerging as addictions needs or simply as an educational tool to use in educating First Nations community members concerning trends affecting them as individuals, their children and their community. This would include issues arising out of recent reports issued by the Auditor General and potential problem areas of prescription drug abuse and the rising concerns regarding forms of gambling in particular bingo.

If one applied the benchmark envisioned in the cabinet document that the program in its mature state should devote 5% towards research and development, this would amount to $2.75 million on an annual basis out of a total estimated $55 million dollar program. While it would be obviously difficult for Health Canada to simply reconstitute this fund out of thin air, there would be an advantage for both Health Canada and First Nations and Inuit organizations to oversee a partial reconstitution of this budget and to combine this amount with funding anticipated by Health Canada to establish an Aboriginal Health Institute(s) and centers of excellence recently announced as part of the government response to the Royal Commission.

3.9 Information Systems

The NNADAP program would benefit from outcome information, if the data could be obtained systematically during each stage of assessment, treatment and follow-up. This information would be invaluable for ensuring that the various persons involved throughout the treatment process carry out their respective responsibilities. Systematic and routine evaluation of program components would ensure improved and continued effectiveness.

There is an important opportunity to build systematic follow-up and client outcome information into an overall health information system targeted at the community level. In the Ontario region of Health Canada, a comprehensive community based health information system has been developed, which has a component for alcohol and drug abuse. This registry could be modified to schedule follow-up with very minor modifications and could also be utilized to track client progress. Of considerable significance to this study, is the potential of this system for networking with other providers within the health system such as community health nurses and mental health providers.

Since Medical Services Branch has obtained new resources to implement the H.I.S. system across the country, it would seem logical that such a system could accommodate the modification described above. It would be essential to have this system cover the 49 treatment centers within the same networking plan. Such a system would be a critical means of tracking follow up to treatment programming, as well.

In addition, although there will be sufficient challenges in implementing the scenario described above, there should be contact made with the Department of Indian Affairs with respect to systems in place for Child and Family services programs to determine whether there are opportunities to review existing or future information systems to explore case-working and coordination opportunities.

3.10 Program Evaluation

Program evaluation is a process used to determine whether or not the objectives of a program have been achieved. It should be an integral part of the program planning process rather than an afterthought. There are two types of program evaluation: formative (or process) and summative (or impact) evaluation. Formative evaluation examines activities associated with the ongoing operations of a program. Summative evaluation examines activities associated with the more long-term effects or impact of a program. Both types of evaluation are important, because conducting one type of evaluation while excluding the other type could result in incorrect conclusions being made about the performance of the program.

In order to perform effective program evaluation, the program elements must be very well defined. There must also be measurable objectives developed, which describe the change that one would like to achieve in a particular program, as well as the magnitude of the change and the time frame within which the desired change is to be achieved. In addition, baseline data should be collected to provide a snapshot of the situation that existed prior to the implementation of the program. Each objective must be associated with realistic outcome measures or performance indicators, and a data collection process must be in place to provide reliable data for ongoing monitoring of program performance, as well as for subsequent comparisons with the baseline data.

A portion of this General Review of the National Native Alcohol and Drug Abuse Program focused on the issue of program evaluation and it identified many gaps and inherent weaknesses this General Review of the National Native Alcohol and Drug Abuse Program focused on the issue of program evaluation and it identified many gaps and inherent weaknesses

Findings

- ***There is no standardized approach to the collection of reliable data for ongoing monitoring of program performance at the community level.***

- ***Survey respondents and participants during the on-site community visits identified the need to develop a systematic approach to the evaluation of the effectiveness of the NNADAP program.***

- ***Much of the evaluation of NNADAP that has occurred has focused on process issues (e.g., bed occupancy rates) rather than actual patient outcome.***

- ***NNADAP Treatment Centers tended to have more structured evaluation processes than did the community-based elements of the NNADAP Program. However, treatment center evaluations were more focused on program design rather than actual patient outcome measures.***
- ***At the regional level, program evaluation does not appear to***

be a priority. In some regions like Saskatchewan, however, a formal process of evaluation has been established to assist in the ongoing monitoring of program activities so those problems can be addressed as they arise. Again the focus tends to be more on process rather than outcome.

- *At the national level, only TARS and expenditure data are available for analysis. No direct focus has been placed on the issue of effective program evaluation, particularly as this pertains to the assessment of the overall impact of the NNADAP Program.*

In order to address future requirements for effective program evaluations, Health Canada should support development of a training package on program evaluation which could be used to train NNADAP staff and treatment centre and at community level to perform effective program evaluation. This package should address both process evaluation and impact evaluation. There must be sufficient resources to assure that staff have the necessary training.

Health Canada in collaboration with stakeholder representatives should develop a core list of performance indicators to be used by regions to conduct a process and impact evaluation of the NNADAP on an annual basis. This list could be adjusted to satisfy local requirements. However, a core list of indicators would facilitate a regional comparisons of program performance and would allow Health Canada and First Nations and Inuit organizations to have a national perspective of the impact of the NNADAP.

There is an obvious need for reliable computerized data collection processes that will provide data on an ongoing basis for case management and for program evaluations. Health Canada with the stakeholder group should establish a working group to examine data requirements and potential sources of data for effective case management and ongoing evaluation of the NNADAP. For example, this group could examine the possibility of using abuse profile subsystem of the National Health Information System as one of the potential sources of data for NNADAP.

It is imperative that any computerized system identified to collect reliable data should also provide data for NNADAP staff for case management purposes. In fact the primary focus of such as system should be to support the day to day activities of the NNADAP staff. The availability of aggregate reports for program planning and evaluation should only be a secondary benefit of the system. If the system is not capable of supporting the work of NNADAP staff in case management activities, there will be little support for the system at the community level and the availability of data for program evaluation will be significantly diminished.

4. DISCUSSION OF GENERAL TRENDS

In examining the outcomes of this review, there are several trends, which are present within the overall elements of the review, which should be highlighted.

4.1 North-South Issues

In visiting communities, there were several variables for northern or remote communities, which create unique challenges to addictions programming in particular, and in general to other health and social services programs.

Transportation costs are the most obvious of the variables which impact programs and limit choices both for individual residents and for program staff. However, transportation has other impacts, which are not totally related to the increased cost of providing services. At times, issues such as the location of the airstrip have major impacts on the ability of the community to deal with addiction issues. For example, in Garden Hill, Manitoba, the community has to use an airstrip, which is not on reserve. Aside from the complications arising from having to shuttle across the lake, this also makes it impossible for the community to prevent alcohol and drugs from being brought into the area and thus into their community. Location of the law enforcement and detention facilities can also be seen as having an impact on the community's ability to deal with problems in a consistent and appropriate manner.

Staff recruitment presents varying types of problems. For example, depending on the size of the community and its history of post-secondary education, there may not be a pool of potential employees within the community who would meet the entry requirements for NNADAP sponsored training programs. Further, once persons are trained, a combination of lack of salary adjustment for isolated locations and comparatively low salaries generally mean that the person in the position is recruited to other higher paid jobs. For those communities who recruit from other communities to fill positions, such persons tend to leave after completing training. Obviously, there are exceptions and there were numerous examples of dedicated people whom we met during the field visits.

Observations on areas of challenge identified in the review tend to be accentuated in northern or remote communities. By their nature, communication issues and support, training, access to provincial services, and availability of beds has more of an impact. At the risk of generalizing, it could also be stated that the emphasis on treatment within northern communities is also an issue, which has implications for workers in the field.

4.2 Focus on Treatment

To a great extent, the focus on treatment needs for individuals within communities tend to dominate the agenda for the NNADAP program. This circumstance continues despite many efforts taken on the part of key decision-makers and programmers such as NNADAP Headquarters personnel, regional First Nations organizations, training institutions and other key players, to develop other emphasis. For example, considerable effort was applied to develop a prevention framework for the NNADAP program utilizing key stakeholders.

It is important to clarify that the above statement is not intended to be a criticism of the program or its personnel. Rather, it should be stated in almost all cases there are real treatment needs within the community, and that those needs are felt directly by the leadership. The leadership, in turn, expect the alcohol and drug abuse worker to directly provide services, or at least to be the key individual who can assist a person or family in a time of need.

This dilemma is not unique to addictions programs. The same issue and expectations also are present in other health and social programs. For discussion purposes, an example which illustrates this circumstance, is a person suffering from complications of diabetes such as potential amputation. The best advice and scientific evidence available have shown that the best approach to dealing with Type II, adult onset diabetes is to delay or prevent the onset of diabetes through a combination of exercise, nutrition and other lifestyle approaches. However, even such practices are not a guarantee that the individual will not suffer from diabetes or its effects. For those persons diagnosed with Type 1 or early onset diabetes, the aforementioned measures will not affect onset, but rather may mitigate the long-term impact of diabetes.

A health professional who ignores the treatment needs of the person described above will do real damage to the person and also potentially diminish his or her credibility within the community. The challenge in this situation is to change the community's perceptions about diabetes and to implement the measures described above which will have payoffs for the entire population. In doing so, there will have to be careful planning, use of key individuals to promote proper lifestyle behavior, and proper educational activities targeted at groups such as the community leadership.

The parallels to addictions in the community are unmistakable. The challenge for NNADAP as an overall system is to recognize the current circumstances, which reflect a certain requirement for treatment while strategizing about the means of moving the balance of services towards a prevention and health promotion emphasis. In doing so, it must be recognized that wellness and health promotion need to be orchestrated much like a social or political movement. An example of an extremely effective approach is the National Addictions Awareness Week (NAAW) coordinated by the Nechi Institute.

It must be recognized that the most effective means to promote such a movement within the First Nations and Inuit populations of Canada is through the support of existing aboriginal institutions and the support of new initiatives such as an Aboriginal Health Institute and centers of excellence.

Less dramatic but also effective in supporting health promotion, prevention and early intervention are such measures as: establishing well publicized annual goals for NNADAP (or for Health Canada), by hosting conferences to support health promotion and prevention concepts, and by developing public relations and communications material.

4.3 Impact of other health and social cutbacks

The NNADAP financial history has been reviewed as part of this study. However, this financial review only examines one dimension of a complex financial picture. It must be recognized as well that there are cumulative effects of other fiscal measures taken by a variety of jurisdictions. Some of these measures or decisions are as follows:

4.3.1 Federal

DIAND, followed by Health Canada, eliminated per diems for individual patients in treatment programs. Originally, such per diems were intended to be a supplement for individual clients to pay for sundry items such as personal hygiene products. These costs were subsequently either passed on to the client or absorbed by the treatment program.

Non-Insured Health Benefits Program has controlled costs by instituting a series of reductions as follows:

- Out of country treatment services and Non-NNADAP treatment programs have for all intents been eliminated

- There are restrictions on referral of clients out of the region even if attending a NNADAP treatment program.

- Medical transportation has been converted to a program and will be transferred to community control

The envelope funding concept for Health Canada has eliminated the practice of approaching central agencies to examine individual programs' needs and has resulted in the discontinuance of the Community Workload Information Systems (CWIS).

The Human Rights Tribunal rulings on compensation for various occupational groups such as nurses and CHRs have caused federal departments to eliminate salary figures in contribution and transfer agreements. This makes it difficult to mount arguments based on wage parity since there are no references to wage levels.

There has been minimal or limited growth in contribution funds in the past five years due to federal constraint. NNADAP has the additional disadvantage of not receiving incremental increases in the period immediately prior to this period of constraint.

In addition, some of the reductions referred to in the NNADAP financial study have been carried out to respond to fiscal reduction targets imposed either by the Government of Canada as part of its overall reduction plan or by Health Canada to deal with internal fiscal pressures.

4.3.2 Provincial

Provincial health care reform has reduced or eliminated many services, which directly or indirectly have an impact either on treatment programs or individual clients. Some examples of this include:

- Reduced availability of hospital beds which affects the availability of detoxification services

- Most provincially insured services programs limit or eliminate referrals to out of province or out of country treatment programs
- Most provinces have also eliminated payment for medical checkups. This sometimes is an immediate barrier to treatment since costs generally are in the $100 range.

Due to reductions in the rate of growth of Federal/provincial transfer arrangements, provinces have concerns about providing health and social services to First Nations and Inuit people who are constitutionally defined as a federal responsibility.

Reductions in mental health and trends towards de-institutionalizing mental health patients are creating additional pressures in programs such as NNADAP.

4.3.3 Federal and Provincial

Early release programs for federal and provincial penal institutions and alternative sentencing are creating additional demands for treatment for which there has not been a corresponding investment of funding by these respective jurisdictions.

4.4 Summary and opportunities for advancing issues

As described above, it can be readily seen that there are complex fiscal challenges facing NNADAP as a program, and as part of the health and social services system. Accordingly, there will have to be complex and well developed strategies for dealing with the obvious need for additional resources identified in this study.

A key example of this is the issue of wages. This issue was identified by a vast majority of individuals within the program. However, dealing with the issue of appropriate wages will demand a carefully developed strategy to achieve progress. To simply accept the statement from Health Canada that there is no funding available is not productive. There are a number of fiscal implications arising from this report. It will require a true partnership approach between Government of Canada and First Nation and Inuit people to deal with these challenges. An effective partnership also will require the development of a careful and realistic strategy to ensure that the necessary supports are provided to the NNADAP in order that First Nation and Inuit communities will be able to deal with the challenges of today and the future.

In order to support necessary program changes, funding criteria should be designed to reinforce adherence to essential areas of development raised by this report. For example, providing funding incentives or flexibility or other strategies would make it desirable to adhere to National Standards, to implementing proper data systems, to evaluate programs or to attain accreditation as a worker.

As a first step, it will be extremely important to exhibit a renewed commitment by both Health Canada and First Nation and Inuit organizations to the support of programs dealing with the addictions issues faced by communities.

In developing and carrying out the details of this strategy, there are a number of considerations and opportunities that should be examined related to the wage issue and other financial issues raised by the report.

Obviously, Health Canada should review the detailed financial report and determine the potential to reallocate resources to deal with the areas, which have been adversely affected by budget reductions over the years.

Similarly, First Nation and Inuit communities should also examine themselves from a similar perspective as may be illustrated by the following possibilities:

1. First Nation and Inuit communities have had a series of new programs and initiatives within mental health and mental wellness over the last 5 years for which the respective First Nation or Inuit community has considerable latitude in spending. Brighter Futures and Building Healthy Communities could be considered for supporting various elements within an overall community wellness strategy, which could include NNADAP.

2. Individual First Nation communities should also review funding agreements to determine whether available salary dollars were provided to NNADAP workers. In some cases funding was split into two workers or the full salary was not given to workers.

3. Communities under transfer agreements have the opportunity to review salaries as per their internal requirements and budgetary constraints.

Health Canada in partnership with First Nation and Inuit organizations should also jointly strategize opportunities to deal with addictions needs through resources available in other jurisdictions. The following is a list of potential opportunities from the federal, provincial and private sectors:

1. Federal Crime Prevention fund which currently has no criteria for First Nation participation.
2. Similarly, the Proceeds of Crime legislation could be examined for areas of potential interest and benefit for communities.
3. Studying the implications of early release and alternative sentencing programs and negotiating with federal and provincial sources for funding to support these efforts.
4. Casino profit sharing or seeking funding from federal or provincial gambling sources to deal with issues relating to gambling addictions.
5. Use of resources under tobacco addictions programs at the federal and provincial level.
6. Consideration could also be given to the pros and cons of soliciting funds

from tobacco companies and breweries to deal with various issues and programs.

7. Developing a definite role for addictions programs in the healing and wellness strategy.
8. Developing arrangements by which NNADAP programs could be part of EAP services for First Nations and Inuit communities.
9. Developing fee for service arrangements for which training can be provided to NNADAP workers as well as other health and social services workers at the community level.
10. Examining the viability of acquiring funds under provincial programs.
11. Examining Non-Insured Health Services to determine opportunities to develop mutually beneficial strategies such as prescription drug abuse prevention, intervention, and treatment programs.

In conclusion, while there are many needs, there are also opportunities to deal with these needs. However teamwork, effective strategy, and follow up will be essential for success.

4.5 Evolution of Aboriginal Self Government

The concept of government to government relationship with First Nations and Inuit and the realization of new partnerships as a result of the Royal Commission on Aboriginal peoples will have a real impact on the developments recommended in this report; and more importantly, the style in which these recommendations are implemented.

In the federal response to the RCAP report entitled "Gathering Strength- Canada's Aboriginal Action Plan" there four objectives contained which were intended to serve as the first step in the long process of establishing a working government to government relationship between the federal government and First Nations governments. These objectives are as follows:

- Renewing the partnership
- Recognizing and strengthening First Nations governments
- Equitable and sustainable fiscal relationships
- Supporting stronger First Nations communities and people

As may be seen from this type and style of response, there will be implications for the follow-up to the NNADAP review to assure that such responses are consistent with current trends in Federal – First Nations relations. However, it is important to state that these recommendations have been developed with this overall philosophy in mind, and that there is an explicit recognition of the need for First Nations and Inuit people to be empowered in dealing with their health and social issues.

Some examples of areas affected by this style of approach are as follows:

- Examining the issue of implementation of standards, information systems, and evaluation will have to be done from the perspective that First Nation and Inuit organizations will have to be explicitly involved with the design and approval of such developments.
- Creation of First Nation and Inuit Institutions will be a key strategy in implementing change and promoting program concepts within communities. Control and ownership of such program elements formerly seen as controlled by Health Canada such as accreditation processes and systems for collecting data will be the most important element in acceptance by communities.
- Increasing levels of resources are now under First Nation control and there is a likelihood that this trend will continue. First Nation and Inuit organizations and aboriginal organizations, in general, will have an increasing role to play in determining government funding priorities. There will be an interest by both parties in moving towards province like transfer agreements with minimum requirements or standards.

5. Summary

The future effectiveness of addictions programs will to a large degree be dependent on:

- The commitment of Health Canada and key representatives from First Nations and Inuit organizations to make addictions a priority.
- The commitment to support effective capacity building through developing First Nations and Inuit institutions to support community based efforts.

6. RECOMMENDATIONS

1. The use of legally obtained and illegally produced or sold alcohol remains a major issue that affects the whole community. It is recommended that there

be a renewed focus and commitment which comes both from Health Canada and First Nations to deal with this issue. This should also be coordinated with law enforcement and crime prevention specialists.

2. The use of illegal drugs is a rising and pernicious concern at the community level. The establishment of a task force to examine means of dealing with the issue of illegal drugs is recommended. Further, that this task force be composed at minimum of First Nations and Inuit, Health Canada, Justice, RCMP, and Solicitor General. The focus for this task force would be the development of strategies to improve coordination, planning and funding of community needs.

   Further that the Justice Department, Health Canada with First Nations and Inuit organizations have joint discussions on coordination and funding priorities within the crime prevention funding initiative to deal with the illegal sale of alcohol and drugs.

3. The issue of prescription drug abuse should be examined. This could be achieved through a review of system delivery and a more thorough examination of this issue through surveys coordinated with the Health Promotion Branch Senior Research Program. The possibility of devoting one or more centers to deal with prescription drug abuse and/or to provide training to communities should seriously be considered.

4. Gambling is an issue that is on the rise and should be dealt with before it becomes even more pervasive. Health Canada and First Nations and Inuit leaders must jointly negotiate with respective provincial and national beneficiaries of various types of gambling such as lotteries, pull-tabs, and casinos. Resources should be negotiated for determining incidence levels, in designing appropriate information campaigns and in providing necessary intervention and treatment services.

5. Solvent is an important issue. It is recommended that the solvent abuse program be integrated into the overall NNADAP program to enhance success of both programs.

6. Health Canada should reinstate a structured research program that would provide a means of tracking and anticipating areas of program need. In developing this structured program there should be an implementation committee consisting of persons experienced in research from First Nations and Inuit communities and organizations such as in Addictions Research Foundation (ARF) of Ontario and the Alberta Addictions and Drug Abuse Commission of Alberta. It is also recommended that both Health Canada, AFN and Regional and Provincial First Nations organizations make a commitment to include addictions questions in the next iteration of the First Nations longitudinal health survey currently underway.

7. To develop revised scope of duties for the community workers, which should take into consideration advanced and basic counseling. There should also be recognition and a training strategy developed to assure that NNADAP workers have skills in areas of grief and loss, family violence, sexual abuse, tobacco,

gambling, and other areas. Sample protocols should be developed to assist communities in dealing with 24-hour requirements and means for handling on-call within communities. (This should be related to the recommendation on a national accreditation process.)

8. There should be work plans and procedures developed to assist workers to focus on areas of need within communities. Health Canada and First Nations should develop strategic and annual priorities that will assist the program in providing necessary focus, leadership, and support to communities. In developing work plans and procedures, there needs to be particular emphasis on dealing with prevention, intervention, and treatment strategies for adolescents and in coordinating with other health and social programs within the community.

9. That there be a National Social Marketing Strategy developed with Medical Services Branch to support program goals in prevention to correspond with the population health model.

10. There should be an overall program estimate developed for basic coverage for communities to deal with addictions. This costing should be developed from the perspective of types of services and programs that should be made available in each community. Part of the package should identify the context in which advanced counselors would be recognized and those circumstances whereby part-time workers are necessary. This will facilitate a process by which First Nations leadership can more effectively allocate funds available for the programs and to determine potential short-falls. Health Canada and First Nations should consider these estimates as a benchmark for all communities and determine opportunities to meet needs. Such a process should be linked to the implementation of an outcome based reporting system.

11. As part of an overall accreditation process, a group of stakeholders should be involved in developing a code of conduct for NNADAP workers which could be posted in First Nations' buildings and in NNADAP offices. This would outline expectations relating to confidentiality, obligations, possible remedies and penalties where there are violations. (See recommendations on training).

12. Health Canada in a lead role with First Nations organizations should conduct the necessary legal and programmatic research to develop standard protocols for release and sharing of information. There should be a particular focus on networking, information sharing, and protocols with social programs such as child and family services and social assistance programs.

13. Various organizational models should be documented which will assist in communities to coordinate services and/or integrate NNADAP with other programs and services in particular with health and or social services agencies.

14. Health Canada should take a lead role in collaboration with a steering committee of stakeholders to develop facility models, which would enhance client perceptions of confidentiality. This concern is also related to similar requirements associated with program initiatives in mental health, child

welfare, and social services. Part of the study should identify costs to make facility, equipment, or office furniture modifications for ensuring confidentiality.

15. That Health Canada determine opportunities to supplement funding from other sources including provincial and other federal departments for NNADAP Treatment Centers.

16. It is recommended that treatment centers consider reorienting their summer programs to assist in the delivery of programs carried out in their area cultural camps. It is also recommended that treatment centers who deliver programs in cultural camps do not lose funding.

17. It is recommended models be developed to for "couples" treatment. This would be a practical alternative to family treatment , which would eliminate complications arising from having multiple age groups and family units in programs.

18. It is recommended that Health Canada review its present funding process and formula and factor in isolation, actual costs, effectiveness and efficiency to ensure they are equitable with other services such as provincial addictions agencies.

    Further that Health Canada and First Nations examine means by which Treatment Center budgets could be increased to provide orientation, training and treatment in grief, loss, cultural programs and in treating other emerging addiction areas such as gambling, prescription drug abuse, etc. This could be achieved through better coordination and seeking interest with other federal and provincial governments in cost sharing, applying fee for service with other programs including child welfare, alternate sentencing and early release programs, etc. Additional monies should be made available to residential treatment centers for the purpose of providing their counseling staff training in mental health areas such as victims of sexual abuse, violence, residential school affects, loss and grief and abandonment issues and general post-trauma processes.

19. That pre-treatment programs be developed or models for both the community level and treatment centers. Pre-treatment can be defined as an assessment, orientation, and readiness phase to treatment for clients. Length of pre-treatment programs should vary depending on the treatment program itself and range in length from one week to three weeks.
    That existing pre-treatment programs such as the one developed by Society of Aboriginal Addictions Recovery (SOAR) for Corrections Services Canada be considered as a possible resource.

20. TARS needs to be revisited with input from all the treatment centers that use this system. Efficiency and cost analysis of either developing a new national system or allowing treatment centers to develop their own data system needs to be explored in order to determine the most effective response to drug and alcohol issues.

    TARS or its replacement needs to have additional capabilities such as tracking client outcome and measuring quality assurance programs for the treatment centers.

21. Health Canada, First Nations and Inuit organizations should negotiate accreditation with groups such as Ontario Interventionist Association to utilize certified alcoholism counselor title or develop a similar accreditation process. The program could also consider granting parallel privileges to individuals with certain educational qualifications as well such as Bachelor of Social Work (BSW), Master of Social Work (MSW), psychology, or other fields which would be considered as equivalent.

22. That Health Canada and Human Resources Development Canada conduct a labour market survey in aboriginal health training particularly in areas of alcohol and drug abuse, early childhood, health promotion, mental health. This survey should be aimed at determining resources required due to the changing needs of community.

23. Health Canada in collaboration with a steering committee of First Nations and Inuit representatives and representative stakeholders within the various NNADAP workers should develop a new training strategy to enable the communities to respond to the directions contained in this review. A second task would be to develop an inventory of courses that may be shared with different jurisdictions. This strategy should include a review of accreditation options and should include development of a strategy to meet the considerations of recognition, targeting of training resources to positions, advance training, and multi-disciplinary training.

Health Canada in collaboration with First Nations and Inuit representation should finalize concrete measures through an organized system of capacity building at the community level. That strengthening capacity within the management, planning and evaluation receive priority in the work plan.

In finalizing these measures, the concepts presented on Centers of Excellence, Treatment centers as training centers, and promotion of communities as models of best practice should be considered within the overall plan.
Coordination with other federal departments such as DIAND and Regional Advisory Board, Human Resources Development (HRD), Corrections Services Canada will be essential to the implementation of common areas of interest.

24. It is recommended that all addictions programs within Health Canada be integrated into one system for dealing with addictions. This integration should include the development of common strategies for research, information gathering, training, and information dissemination.

25. That the federal government and First Nations and Inuit organizations encourages models of integrated programming through recognition of such communities as role models and centers for information exchange and training. Further to provide resources to community-based resource centers

to ensure their communities do not suffer when they assist other communities.

It is further recommended that Health Canada support development of integrated models of health care through funding of an Aboriginal Health Institute and centers of excellence.

26. It is recommended that Health Canada review financial and program development requirements for treatment in advance of allowing use of treatment centers for other purposes.

It is recommended that Health Canada and First Nations consider development of regional and national healing strategies, which would involve working groups consisting of relevant groups such as community NNADAP workers and treatment centers among others.

It is further recommended that a study of existing healing lodges be carried out to investigate the potential benefits and liabilities of this approach.

Finally, as part of an overall strategy, there is merit in having a pilot project, which would examine in detail, and implications of changing focus for treatment centers.

27. It is recommended that Health Canada and First Nations and Inuit organizations support communities and treatment programs through funding a National Aboriginal Addictions organization or by funding a strong and distinct addictions element within a National Aboriginal Health Institute.

It is further recommended that a directed research program be partially reconstituted as a priority by Health Canada, and potentially augmented by funds from the Non-Insured Health Benefits program to deal with alcohol, drugs, solvents as well as emerging addictions issues such as prescription drug abuse and gambling.

28. It is recommended that Health Canada and First Nations and Inuit representatives implement the center of excellence concept to promote communities and treatment centers with recognized strengths and expertise as training and support mechanisms for other communities and treatment centers.

29. Discussions should be held with treatment centers to determine feasibility of having treatment centers as service hubs for community workers in such issues as general orientation, training on referral and assessment, information on addictions and other addictions and coordination needs which have been expressed from both treatment centers and the community level.

30. Health Canada, through a steering committee of stakeholders should develop and implement a system similar to the Ontario Drug and Alcohol Abuse Rehabilitation and Treatment (DART) system which will assist community workers in determining availability of treatment programs and in matching needs of clients to those system.

It is further recommended that Health Canada develop a basic mandatory aftercare/follow-up system. The Round Lake Treatment center system should either be adopted or revised to take advantage of quality work done in this area. Similar to the preceding recommendation, this work should be done through use of a steering committee of key stakeholders. This work would be critical in implementing an outcome system as described in the preceding paragraph.

Ideally, this system would interact with provincial treatment systems as well to make use of other services available; for cocaine addiction, prescription drug misuse, gambling or detoxification.

31. The Health Information System developed by Ontario region within Health Canada should by reviewed and revised to serve as an outcome measurement system. This system should be oriented to providing a schedule for follow-up on clients as well as case management with other providers within the health system such as Community Health Nurses, Mental Health services and other providers using this system.

32. Health Canada should develop a training package on program evaluation which could be used to train NNADAP staff and treatment centres at the community level to perform effective program evaluation. This training package should address both process evaluation and impact evaluation.

33. Health Canada in partnership with various stakeholders should develop a list of core indicators to conduct process and impact evaluation of the NNADAP.

34. There is a need for a reliable data collection processes that will provide data on an ongoing basis for case management and for program evaluation. A working group should be established to examine data requirements and potential sources of data for effective case management and for the evaluation of the NNADAP on an ongoing basis. This working group should examine the use of the abuse profile subsystem of the Health Information System as one of the potential sources of data for the NNADAP.

    It is imperative that any system for collecting data for program evaluation also data to NNADAP staff for case management purposes. The primary focus of such a computerized system should be to support the day to day activities of NNADAP staff. If the system does not support the work of NNADAP staff in case management, there will be little support for the system at the community level and the availability of data for program evaluation will be significantly diminished.

35. Health Canada should clarify or eliminate policies, which have resulted in unwanted barriers to treatment in areas such as transportation to treatment in order to eliminate problem areas in multi-regional issues such as access to specialized programs.

36. That internet support be considered for aboriginal youth focusing on prevention initiatives.

Further, that resources to access internet at a program level be establish to assist in national program communications.

37. That Health Canada in a partnership approach with First Nations and Inuit organizations representatives develop a working group to develop a work plan to oversee response to this review. It is further recommended to establish a 6 month deadline for this work plan. Further consideration should be given to establishing regional groups to examine recommendations from this review.